# Maternal and Child Health Services
# Title V Block Grant

# State Narrative for South Dakota

## Application for 2013
## Annual Report for 2011

Document Generation Date: Monday, September 24, 2012

# Table of Contents

# I. General Requirements

## A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
***An attachment is included in this section. IA - Letter of Transmittal***

## B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

## C. Assurances and Certifications

Copies of the assurances and certifications are provided as an attachment to this section. The originals are maintained in the South Dakota Maternal and Child Health (MCH) program's central office.

The MCH program further assures it will: (1) use funds only for the purposes specified; (2) identify and apply a fair method to allocate funds to groups and localities; (3) apply guidelines for appropriateness and frequency of referrals; (4) use funds only to carry out the purposes of this title; (5) publish charges for services, not impose charges for low income, and adjust charges for income and resources; and (6) at least every 2 years audit expenditures and submit a copy of the audit report to the Secretary.

***An attachment is included in this section. IC - Assurances and Certifications***

## D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2012; expires January 31, 2015.

## E. Public Input

State performance measures were developed based on the state's comprehensive needs assessment. The South Dakota Department of Health (DOH) made the FY 2011 MCH block grant available for public review and comment via the DOH website at doh.sd.gov/news. A summary of the plan was put on the website on May 3, 2010 with comments due back to the DOH by June 30, 2010. Information on how to obtain a complete copy of the application for review was also provided on the website. No comments were received. The MCH program interacts daily with the MCH population and partners which allows the MCH program to respond to any identified areas of need and build those recommendations into the annual plan prior to the block grant being available for public review.
/2012/ A summary of the plan was put on the website on May 18, 2011 with comments due back to the DOH by June 30, 2011. No comments were received. //2012//
***/2013/ A summary of the FY 2013 state plan was made available via the DOH website on May 22, 2012 with comments due back to the DOH by June 30, 2012. In addition, the summary was provided to all DOH Community Health offices to display for clients to request, review, and provide comments on the state plan. No comments were received. Based on the DOH experience with other grants, it is not an effective use of funding to advertise in South Dakota newspapers regarding the opportunity for public review and comment on grant applications or state plans. The MCH program's daily interactions with the MCH population and partners is a far more effective means for the MCH program to***

***respond to any identified areas of need and build those recommendations into the annual plan. //2013//***

The MCH program works throughout the year with many different programs and stakeholders around the state including DOH programs (i.e., Nutrition/Physical Activity, Tobacco Prevention, Family Planning, Diabetes, etc.), Department of Social Service (DSS), Department of Human Services (DHS), Department of Education (DOE), Department of Public Safety (DPS), Department of Transportation (DOT), Delta Dental, Dakota Smiles Mobile Dental Program, South Dakota State Medical Association (SDSMA), South Dakota Association of Healthcare Organizations (SDAHO), South Dakota Dental Association (SDDA), HELP! Line, respite care, Aberdeen Area Indian Health Services (IHS), Great Plains Tribal Chairman's Health Board (GPTCHB), Great Plains Tribal Epidemiology Center (GPTEC), Healthy Start directors, school nurses, University of South Dakota (USD) School of Medicine, South Dakota Parent Connection (SDPC) (Parent Training and Information Center), USD Center for Disabilities, and pediatric specialists. Through participation in these many different projects and meetings, the MCH program constantly receives informal public input on additional opportunities to collaborate and improve efforts to serve the MCH population in South Dakota.

# II. Needs Assessment

In application year 2013, Section IIC will be used to provide updates to the Needs Assessment if any updates occurred.

## C. Needs Assessment Summary

Priority needs for the South Dakota MCH block grant are based on the five-year needs assessment completed for the FY 2010-2015 MCH Block Grant cycle. The following priority needs in South Dakota cross the four levels of the public health services pyramid and are measured through both national and state performance measures:

• Reduce unintended pregnancies;
• Improve pregnancy outcomes;
• Reduce infant mortality;
• Reduce morbidity and mortality among children and adolescents;
• Improve adolescent health and reduce risk-taking behaviors (i.e., intentional and unintentional injuries, dietary habits, tobacco use, alcohol use, and other drug utilization);
• Reduce childhood obesity;
• Improve the health of, and services for, children and youth with special health care needs (CYSHCN) through comprehensive services and support;
• Improve and assure appropriate access to health services that are focused on families, women, infants, children, adolescents, and CYSHCN; and
• Improve state and local surveillance and data collection and evaluation capacity.

The priority needs have not changed from the 2005-2010 MCH Block Grant cycle as it was determined the priority needs were still an accurate portrayal of South Dakota.

South Dakota's assessment team included representatives from CYSHCN, Women, Infants, and Children (WIC), perinatal health, adolescent health, sexual violence prevention, family planning, newborn screening, oral health, tobacco prevention/control, nutrition, epidemiology, and data. The team used national performance measures and health status and capacity indicators as the starting point for the review. Stakeholders were involved to provide additional data and/or clarification.

The assessment was conducted in two phases. In Phase 1, for each area the assessment team looked at population served, trend data, other data sources and identified gaps, strengths, resources, and partners. Based on this review, potential state performance measures were narrowed down to eight. In Phase 2, results of phase 1 were disseminated to public and private stakeholders not represented on the assessment team via focus groups to identify other resources, collaboration opportunities, and identification of possible duplication of efforts. Stakeholders included Healthy SD, Children's Mental Health Initiative, Roadway Safety Committee, Family Planning Workgroup, SDPC, Newborn Screening Program medical consultants, Healthy Start, Community Health, and Tobacco Prevention and Control Advisory Committee

The 2005-2010 needs assessment team used the CAST-5 self-assessment tool. This tool was not used for the 2010-2015 assessment. However, the process of looking at MCH population groups by Title V health status and capacity indicators, performance measures, and other quantitative and qualitative data was continued during the 2010-2015 assessment.

Stakeholder involvement began during data review. Other programs and agencies were invited to an assessment meeting to provide additional data and/or clarification specific to a given performance measure. This allowed the core assessment team to better identify gaps in data

collection and strengths and weaknesses of present activities and collaborations to address areas of concern. In addition, stakeholder input was received via focused group presentations. Using opportunities when different working groups and/or committees were meeting, the MCH program gave presentations to share data and request input.

The needs assessment did identify that some of the state performance measures needed to be changed to allow the MCH program to capture additional/different data and realign resources and/or activities to meet those measures/activities.

• SPM 1 - Percent of pregnancies which are unintended (mistimed or unwanted) and result in live birth or abortion. (Continued)
• SPM 2 - Percent of singleton birth mothers who achieve a recommended weight gain during pregnancy. (Continued)
• SPM 3 - Percent of pregnant women aged 18 through 24 who smoked during pregnancy. (New)
• SPM 4 - Percent of infants exposed to secondhand smoke. (Continued)
• SPM 5 - Percent of WIC infants breastfed at 6 months of age. (New)
• SPM 6 - Percent of school-aged children and adolescents with a Body Mass Index (BMI) at or above the 95th percentile. (Continued)
• SPM 7 - Percent of high school youth who self-report tobacco use in the past 30 days. (Continued)
• SPM 8 - Accidental death rate among adolescents age 15 through 19 years. (New)

Changes made reflect new opportunities to impact our MCH population and overarching priority needs versus a change in the State's capacity to meet the needs.
***/2013/ The MCH team met throughout the year to review progress toward activities and brainstorm on possible new MCH collaboration activities. During the April meeting, it was identified that SPM 5 would be discontinued as there is no way to remove WIC-only data from the statewide data for comparison. //2013//***

***An attachment is included in this section. IIC - Needs Assessment Summary***

# III. State Overview

## A. Overview

South Dakota is one of the nation's most rural areas. According to 2009 U.S. Census estimates, there are 812,383 persons living within its 75,885 square miles -- and average population density of 10.7 people per square mile. Only three cities in the state have a population of 25,000 or more. Nearly 60% of South Dakota residents live in small, rural communities of 5,000 or fewer people with a significant number living in communities of fewer than 500 people. Of the state's total population, 88.2% are White, 8.5% are Native American, and the remaining 3.3% are classified as some other race. Adults 65 and older comprise 14.4% of the population, which is slightly higher than the national average of 12.8%. South Dakota's population continues to migrate to the eastern part of the state.

According to the 2000 Census, 13.2 percent of South Dakotans live below 100 percent of the federal poverty level (FPL) compared to 12.4 percent for the nation. Over 33 percent (33.1%) of South Dakotans live under 200 percent of FPL compared to 29.6 percent for the nation. When looking at poverty levels for counties on Indian reservations in the state, these numbers are significantly higher with the four largest reservations in the state (Cheyenne River, Crow Creek, Pine Ridge, and Rosebud) representing the five poorest counties (Dewey, Ziebach, Buffalo, Shannon and Todd) in South Dakota. The percentage of the population below 100% FPL is: Dewey (Cheyenne River) -- 33.6%; Ziebach (Cheyenne River) -- 49.9%; Buffalo (Crow Creek) -- 56.9%; Shannon (Pine Ridge) -- 52.3%; and Todd (Rosebud) -- 48.3%. The percentage of the population below 200% FPL is: Dewey -- 66.0%; Ziebach -- 72.1%; Buffalo -- 79.9%; Shannon -- 77.7%; and Todd -- 73.4%.

/2012/ South Dakota is one of the nation's most rural areas. According to the 2010 U.S. Census, there are 814,180 persons living within its 75,885 square miles -- and average population density of 10.7 people per square mile. Only seven of South Dakota's 66 counties have a population of 25,000 or more while 54 of the counties have a population less than 6,000. Only three communities in the state have a population over 25,000 and only 16 communities have a population over 5,000. Over half (51.5%) of South Dakota counties are considered frontier with a population density of less than 6 people per square mile. Four counties are part of a Metropolitan Statistical Area. The remaining 28 counties are considered rural. Of the state's total population, 85.9% are White, 8.8% are Native American, and the remaining 5.3% are classified as some other race or are two or more races. South Dakota's population continues to migrate to the eastern part of the state.

According to 2009 Census estimates, 14.2% of South Dakotans live below 100% of the FPL compared to 14.3% for the U.S. When looking at poverty levels for counties on Indian reservations in the state, these numbers are significantly higher. Of the nine poorest counties in the state, seven are part of Indian reservations and the other two counties are adjacent to a reservation. Poverty levels in these nine counties range from 31.2% in Dewey County up to 62% in Shannon County. //2012//

According to the 2009 Census, 24.6 percent of the state's population are children (under the age of 18) while 7.3 percent are age 4 or younger. Nearly 38 percent (37.8%) of the state's female population is considered to be of childbearing age (age 15 through 44). In 2009, there were 12,516 resident pregnancies (24 of those were to women not in the 15-44 year age range).
***/2013/ According to the 2011 Census, 24.7 percent of the state's population are children (under the age of 18) while 7.2 percent are age 4 or younger. Over 37 percent (37.4%) of the state's female population is considered to be of childbearing age (age 15 through 44). In 2011, there were 11,834 resident pregnancies (24 of those were to women not in the 15-44 year age range). //2013//***
Pregnancies were estimated by totaling resident pregnancies producing at least one live birth, fetal deaths and abortions.

Access to primary care physicians is limited in the state. As of May 2010, there were 1,138 active primary care physicians licensed to practice in South Dakota (family practice -- 533; internal medicine -- 312; pediatrics -- 127; OB/GYN -- 101; general practice -- 65). There are also 818 primary care midlevel providers -- 452 physician assistants, 348 nurse practitioners, and 18 nurse midwives -- located in the state.
/2012/ Access to primary care physicians is limited in the state. As of June 2011, there were 1,034 active primary care physicians licensed to practice in South Dakota (family practice -- 512; internal medicine -- 274; pediatrics -- 110; OB/GYN -- 93; general practice -- 45). There are also 902 primary care midlevel providers -- 449 physician assistants, 427 nurse practitioners, and 26 nurse midwives -- located in the state. //2012// About two-thirds of the state is designated by the federal government as a Health Professional Shortage Area (HPSA). //2012//

South Dakota has 48 general community hospitals, of which 38 are critical access hospitals (CAHs), as well as five IHS hospitals and three Veterans Administration hospitals. There are 28 federally qualified health centers (FQHCs) and 59 rural health clinics. Twenty-two of the community hospitals are currently licensed for obstetrical services.

The economic status of individuals in the state, particularly in the Native American population, is a major barrier to access to services. Another factor to consider is transportation to access services. For some, this means traveling great distances (over 50 miles) to see a primary care provider and even further to see a specialist. On the Indian reservations, this problem is further complicated by the lack of a reliable transportation system. The DOH does allow for reimbursement for travel expenses incurred in traveling to specialty care for CYSHCN.

The Temporary Assistance for Needy Families (TANF) program is a temporary public assistance program administered by DSS and the Department of Labor. TANF is a needs-based program for families with children under the age of 18 (or under the age of 19 of the child is in high school) who need financial support due to: (1) death of a parent(s); (2) parent(s) absence from the home; or (3) physical/mental incapacity or unemployment of parent(s). The primary focus of the state TANF program is to help families help themselves by promoting family responsibility and accountability and encouraging self-sufficiency through work. In state FY 2009, there were 5,012 children receiving TANF benefits.
/2012/ In state FY2010, there were 5,860 children receiving TANF benefits. //2012//
***/2013/ In SFY 2011, there was a monthly average of 6,043 children receiving TANF benefits. //2013//***

The state Children's Health Insurance Program (SCHIP) provides health insurance to children under age 19 who meet certain eligibility guidelines. SCHIP covers doctor's appointments, hospital stays, dental/vision services, prescription drugs, mental health care, and other medical services. SCHIP provides health insurance coverage to uninsured children whose family income is up to 200% of FPL. Children who already have private health insurance may also be eligible for SCHIP to pay deductibles, co-payments and other medical services not covered by their private policy. At the end of FY 2009 (ending 09-30-09), the total number of children enrolled in Medicaid and SCHIP was 71,211.
/2012/ At the end of FY 2010, the total number of children enrolled in Medicaid and SCHIP was 100,368. //2012//
***/2013/ Due to a software change at DSS, FY11 data is not comparable to prior years. FY 10 data will be used until the issue is resolved. //2013//***

In January 2010, the DOH released its DOH 2020 Initiative which provides a clear, concise blueprint for the future activities of the department. The Initiative outlines the goals and objectives for the department as well as key performance measures which will allow the DOH to monitor progress towards these goals. The Initiative also provides detailed action steps for each goal to help guide department activities. Specific individuals have been assigned the responsibility of leading the action steps needed to attain each of the 12 objectives. A copy of the DOH 2020

Initiative is included as an attachment to this section.

Biannual meetings are held between MCH, IHS, GPTCHB, and coordinators from the eight Healthy Start programs in South Dakota (Crow Creek, Lower Brule, Sisseton, Yankton, Pine Ridge, Rosebud, Flandreau, and Cheyenne River). The only tribe in South Dakota without a Healthy Start program is Standing Rock. The group meets to discuss challenges, networking and how to help each other. Areas of discussion have included transportation, sales tax refund on food program; causes of death among the state's Native American population; tobacco use and tobacco prevention efforts for pregnant mothers and exposure to secondhand smoke by infants and children; metabolic screening; updates on the MCH block grant and data specific to the Native American population; family planning services and how to obtain pregnancy tests for clients so they are able to be aware of pregnancy earlier to begin prenatal care, Lifeline Linkup (a telephone assistance program in Indian Country that allows households located on tribal lands to have access to affordable telephone services); Children's Special Health Services (CSHS) program services; EPSDT (early and periodic screening, diagnosis, and treatment) overview; child death in South Dakota including data on causes and rates of death among children; Fetal Alcohol Spectrum Disorder (FASD) project including a discussion of the issues of drinking and pregnancy and the effect on the unborn child; and WIC program.
/2012/ The DOH last met with the Healthy Start programs in April 2010 but due to budget cuts, Healthy Start has not been able to commit to any further meetings. The MCH program is working with the Healthy Start Program Director at the GPTCHB in late July/early August to talk about home visiting, prenatal services at DOH offices on reservations, and discuss partnering and collaboration opportunities between the DOH and Healthy Start. //2012//

In May 2006, the Yankton Sioux Tribe received federal funding from CDC for its Tribal Pregnancy Risk Assessment Monitoring System (PRAMS) project. The Tribal PRAMS project will supplement existing vital statistics data as well as data collected through the department's Perinatal Health Risk Assessment survey and will provide an important source of information to help the state get a better understanding of maternal attitudes, behaviors and experiences for Native American women and their infants in South Dakota. Data can then be used by the state, IHS, tribal health programs, and the GPTEC to target interventions and programs to help improve the health of Native American women and infants. The Tribal PRAMS project will also provide essential data to support progress towards achievement of many DOH Title V priority needs and outcome objectives. The MCH Project Director will contribute to the identification of maternal, infant and child health priorities to be addressed in the Tribal PRAMS project, assist in identifying potential uses of data and mechanisms for dissemination as well as incorporate data to improve programs and services for Native American communities throughout the state.
/2012/ The DOH applied to CDC for a Statewide PRAMS grant in late 2010. The grant application was approved but not funded. //2012//

During the 2010 South Dakota legislative session, no legislation passed directly impacting the MCH population.
/2012/ During the 2011 South Dakota legislative session, there were several bills passed impacting MCH populations:
• SB 22 authorizes birth centers to be licensed and operate in South Dakota. Licensed birth centers must be located within 30 minutes normal driving time of a licensed hospital providing routine birth services. The DOH will be promulgating administrative rules to establish minimum standards for the operation of birth centers including facility safety, infection control, medication control, quality assurance, patient screening assessment, and monitoring including transport protocols and physician referral protocols. Birth centers must adopt, implement, and enforce a written risk assessment system for patients. Only women assessed as low-risk can be accepted as a patient of the birth center and the woman must be continually assessed throughout the pregnancy and care of the client must be transferred to a physician or hospital if the pregnancy deviates from low-risk at any time.
• SB 149 requires DOE and the South Dakota High School Activities Association (SDHSAA) to develop guidelines educating and informing schools, coaches, athletes, and parents of the nature

and risk of concussions. Athletes participating in sporting events sanctioned by the SDHSAA and their parent/guardian must sign a concussion information sheet which will be effective for one academic year. Coaches participating in SDHSAA-sanctioned athletic events will be require to complete a training program developed by SDHSAA and DOE on the nature and risk of concussions associated with athletics, signs and symptoms consistent with concussions, the need to alert appropriate medical professionals in cases of suspected concussions, and the need to follow proper medical direction/protocols for treatment and return to play for athletes suffering a concussion. Athletes exhibiting signs and symptoms consistent with a concussion or suspected of sustaining a concussion will be removed from athletic activity until they no longer exhibit the signs/symptoms and they have received an evaluation and written clearance to return to play from a licensed health care provider.
• HB 1045 permits dental hygienists to provide preventive and therapeutic services under the collaborative supervision of a dentist. Services may only be provided at a nursing facility, extended care facility, or by a home health agency serving the elderly or disabled, a public institution under the Department of Corrections (DOC), DOH, DHS, or DSS, FQHC, a public health facility, a tribal or IHS facility, a mobile dental unit, a public/nonpublic school, or through Head Start or WIC. A dental hygienist may not perform preventive and therapeutic services under a collaborative agreement for more than 13 months for any person who has not had a complete evaluation by the supervising dentist.
• HB 1221 establishes a 20-member task force on teen driving safety under the direction of DPS to evaluate data, laws, and current practices regarding teen driving in South Dakota and provide recommendations for improving teen driving safety to the 2013 Legislature. Appointment of the task force is contingent upon receipt of grant funding. //2012//

***/2013/ During the 2012 South Dakota legislative session, there were several bills passed impacting MCH populations:***
***• SB 23 addresses the issue of synthetic or "designer" drugs (i.e., marijuana or bath salts) by establishing specific categories of the various substances commonly found in synthetic drugs and placing them in Schedule I of the controlled substance statute.***
***• SB 176 establishes a program to assist rural health care facilities recruit eligible health care professionals (i.e., RNs, LPNs, dietitians, pharmacists, occupation therapists, physical therapists, respiratory therapists, laboratory technicians, paramedics, and radiologic technologists). Participants receive a $10,000 incentive payment to practice in an eligible facility for three years.***
***• SB177 establishes a program to assist rural communities recruit primary care physicians (i.e., family practice, internal medicine, pediatrics, OB/GYN), general and pediatric dentists, physician assistants, nurse practitioners, and nurse midwives. Participants receive an incentive payment to practice in an eligible community for three years.***
***• HB 1177 exempts from jury duty breastfeeding mothers of a baby less than one year of age and parents of a baby expected to be born during or immediately prior to scheduled jury duty.***
***//2013//***

/2012/ On January 12, 2011, Governor Daugaard signed an Executive Order reorganizing several state government departments. As part of the reorganization, which became effective April 12, 2011, the Divisions of Mental Health and Alcohol and Drug Abuse as well as oversight of the South Dakota Human Services Center were transferred from DHS to DSS. In addition, the Office of Tribal Government Relations was elevated to a cabinet-level Department of Tribal Relations (DTR). //2012//

The DOH receives $5 million from the cigarette tax for tobacco prevention and control efforts. Funds are used to support cessation and statewide programming, community and school programming, and counter marketing, surveillance/evaluation, and administration. South Dakota offers QuitLine services including coaching, free tobacco cessation products, and three lifetime opportunities for tobacco users to use the QuitLine. South Dakota provides either Chantix or Zyban or patches or gum for QuitLine participants regardless of income.

***/2013/ The DOH receives $4 million from the cigarette tax for tobacco prevention and control efforts. Funds are used to support cessation and statewide programming, community and school programming, counter marketing, surveillance/evaluation, and administration. South Dakota offers QuitLine services including coaching, free tobacco cessation products, and expanded opportunities for tobacco users to use the QuitLine. South Dakota provides either Chantix or Zyban, or nicotine replacement therapy (NRT) patches, lozenges or gum for QuitLine participants regardless of income. //2013//***
Since it began in January 2002, the QuitLine has assisted over 54,000 South Dakotans in their efforts to quit. Data for 2008 indicates the QuitLine has demonstrated a 43% quit rate vs. 5% for people who try to quit on their own.
/2012/ Since January 2002, the SD-QL has assisted over 61,545 South Dakotans in their efforts to quit. The effectiveness of the SD-QL is evident in the 2009 13-month quit rate of 46.4%. //2012//
***/2013/ Since January 2002, the SD-QuitLine has assisted over 66,674 South Dakotans in their efforts to quit. The effectiveness of the SD-QuitLine is evident in the 2010 seven-month quit rate of 47.8% versus 5% for people trying to quit on their own. //2013//***

In May 2010, South Dakota was honored at the National Influenza Vaccine Summit where it received the "Summit Award for Immunization Coalitions/Public Health/Community Campaign" for outstanding efforts and partnerships during the 2009-2010 H1N1 vaccination campaign. In South Dakota, H1N1 vaccination was truly a partnership effort between the state, health systems, hospitals, clinics, schools, colleges, IHS, and community volunteers. The partnership helped South Dakota achieve some of the highest immunization rates in the nation -- vaccinating 34.4% of adults 18 and over for H1N1, the highest percentage in the nation, and had some of the highest coverage rates in several other population groups as well. More than 260,000 South Dakotans were vaccinated. In addition to working with those typical flu vaccine providers, the DOH worked with the three largest health systems to help organize and staff public clinics in the state's larger communities. In other communities, the state relied on local points of dispensing (POD) groups organized by the department to quickly get medications to a large population in the event of a large infectious disease outbreak. DOH "strike teams" gave H1N1 vaccine in communities not served by the health systems or a local POD group, including reservation and tribal lands.
/2012/ The DOH FY 2012 general fund budget was reduced by nearly 11%. The most significant reduction was the elimination of universal flu vaccine for children 6 through 18 years of age. //2012//

Through collaborative efforts, the MCH program has accomplished the following:
• Served 127 children (1992-present) through the long term follow-up (LTFU) for the metabolic program to assure children are receiving appropriate care for their metabolic disorder;
• Utilized the Dakota Smiles Mobile Dental Program to see 11,557 children in 66 communities and provided a retail value of over $5 million in dental care since August 2004;
• Held biannual meetings with Healthy Start directors from eight of the reservation areas to address such issues as prenatal care, family planning, tobacco use, FASD, infant mortality, and transportation;
• Provided rapid HIV testing to 424 adolescents 19 years of age and younger that were at high risk due to lifestyles; continued to provide HIV testing for women when they come in for pregnancy tests;
• Provided influenza vaccines free-of-charge to 22,420 children aged 6 months to 18 years through local DOH offices;
• Increased collection of height and weight data from South Dakota schools from 26.9% of the state's students to 29.3%; obtained data on 40,202 students in these schools;
• Provided respite care to 1,462 children (980 families) with chronic medical conditions, developmental disabilities, and serious emotional disturbances;
• Sponsored outreach genetic clinics in two communities in South Dakota to decrease the travel miles and time for families to access these services;
• Implemented a gestational weight gain during pregnancy initiative to provide educational

materials/toolkit on adequate pregnancy weight gain to all physicians attending births in South Dakota; and
• Expanded the breastfeeding peer counselor program from three to 10 communities.
/2012/
• Served 132 children (1992-present) through the LTFU for the metabolic program to assure children are receiving appropriate care for their metabolic disorder;
• Utilized the Dakota Smiles Mobile Dental Program to see 14,395 children in 68 communities (including 12 Native communities) and provided a retail value of over $6 million in dental care since August 2004;
• Provided rapid HIV testing to 585 adolescents 19 years of age and younger that were at high risk due to lifestyles; continued to provide HIV testing for 1,239 women aged 20-29 when they come in for pregnancy tests;
• Increased collection of height and weight data from South Dakota schools from 29.3% of the state's students to 29.6%; obtained data on 40,945 students in these schools;
• Provided respite care to 1,405 children (906 families) with chronic medical conditions, developmental disabilities, and serious emotional disturbances;
• Sponsored outreach genetic clinics in two communities in South Dakota to decrease the travel miles and time for families to access these services;
• Continued gestational weight gain during pregnancy initiative to provide educational materials/toolkit on adequate pregnancy weight gain to all physicians attending births in South Dakota;
• Provided the breastfeeding peer counselor program in 10 communities;
• Partnered with the Department of Game, Fish, and Parks (GFP) to provide Nature Backpacks to childcare providers and preschools to increase the amount of active time pre-school-aged children spend outdoors; and
• Provided grant dollars to the Sioux Falls School District for a Health and Wellness pilot project to develop strategies for addressing the increasing epidemic of childhood obesity.
//2012//
***/2013/***
***• In CY 2011, followed 138 children (born since 1992) through the Metabolic LTFU program to ensure they received the appropriate care for their metabolic disorder.***
***• Utilized the Dakota Smiles Mobile Dental Program to see 17,367 children in 72 communities (including 26 Native American communities) and provided a retail value of over $7.9 million in dental care since August 2004;***
***• Provided rapid HIV testing to 671 adolescents 19 years of age and younger that were at high-risk due to lifestyles; continued to provide HIV testing for 1,053 women aged 20-29 when they come in for pregnancy tests;***
***• Increased the collection of height-weight data from South Dakota K-12 students from 26.9% to 35.2% of students (49,146 students in 193 schools);***
***• Provided respite care to 1,234 children (756 families) with chronic medical conditions, developmental disabilities, and serious emotional disturbances;***
***• Sponsored outreach genetics clinics in two communities in South Dakota to decrease travel miles and time for families to access these services;***
***• Collaborated with SDPC to provide resources, individual assistance, and training to teach and empower families to work with professionals. SDPC served 900 unduplicated families through 4,382 contacts;***
***• Partnered with DPS to purchase an Impaired Driving Simulator (for a total of three simulators), trailer, and projector/screen used in presentations to high school students across the state;***
***• Provided grant dollars to the Sioux Falls School District for a Health and Wellness pilot project to address the increasing epidemic of childhood obesity; and***
***• Implementing a Safe Sleep campaign which in addition to education of families and providers, includes the provision of a crib for families (Cribs for Kids) who do not have a safe sleep plan or resources to provide a safe sleep environment.***
***//2013//***

One of the biggest challenges for South Dakota and the MCH program continues to be the disparities of the state's Native American population:

• 46.0% of Native American women received prenatal care in the first trimester vs. 71.0% for White women;
• 5-year median infant mortality rate (infant deaths per 1,000 live births) for Native Americans is 2.2 times higher than Whites;
• 29.1% of Native American women smoked during pregnancy vs. 15.9% for Whites;
• 45.7% of Native American students were overweight/obese vs. 31.8% for White students; and
• The birth rate for teens 18-19 years of age for Native Americans was 186.7 per 1,000 women 18-19 years of age vs. 46.4 for Whites.
/2012/
• While the infant mortality rate for Native Americans has improved during the past decade, it is still more than twice as high as the White infant mortality rate (12.3 in 2011 vs. 4.8); and
• The Native American postneonatal mortality rate (5.5) is higher than its neonatal mortality rate (7.0) for 2000-2010.
//2012//
***/2013/***
***• While the infant mortality rate for Native Americans has improved during the past decade, it is still twice as high as the White infant mortality rate;***
***• The Native American postneonatal mortality rate is higher than its neonatal mortality rate;***
***• From 2000-2009, Native Americans accounted for 18% of all births but 32% of all infant deaths; and***
***• From 2006-2009, 30% of Native American women smoked during pregnancy vs. 16.6% for Whites.***
***//2013//***

/2012/ In May 2011, Governor Daugaard announced the appointment of the Governor's Task Force on Infant Mortality to study the state's infant mortality rate and how to reduce it. Task force members are a diverse group from rural and urban areas across the state representing physicians (including family practice, neonatology, and perinatology), nurse midwives, hospitals, rural clinics, social work, the School of Medicine, IHS, GPTCHB, and state agencies (DOH, DSS, and DTR). First Lady Linda Daugaard is serving as the task force chair. The Governor's Task on Infant Mortality will meet throughout the summer and fall and will report its recommendations to the Governor by December 15, 2011. //2012//
***/2013/ The Governor's Task Force on Infant Mortality met throughout the summer and fall of 2011 with meetings held across the state to allow for task force members to receive input from the public. Three subcommittees were established to specifically look at the issues of prenatal care, alcohol and tobacco use, and Sudden Infant Death (SIDS)/Sudden Unexplained Infant Death (SUID). The subcommittees were charged with identifying best practices in South Dakota and nationally that could be adapted or replicated statewide, identifying potential data gaps, and looking at clinical recommendations for consideration by the full Task Force.***

***Throughout the Task Force's discussions, four overarching themes were identified that need to be incorporated into any recommendation or strategy in order to improve birth outcomes and health of infants in South Dakota. These themes included: (1) work in partnership; (2) recognize cultural diversity; (3) use evidence-based interventions; and (4) reduce health disparities***

***The Governor's Task Force on Infant Mortality developed six recommendations and accompanying strategies to reduce the state's infant mortality rate. Because South Dakota has a disproportionate number of its infants dying in the postneonatal period, many of the recommendations and strategies of the Task Force focus on providing a safe, healthy environment for the baby once home from the hospital. Recommendations include: (1)***

***improve access to early, comprehensive prenatal care; (2) promote awareness and implementation of safe sleep practices; (3) develop community-based systems of support for families; (4) conduct statewide education campaigns to reduce infant mortality; (5) develop resources for health professionals specific to infant mortality prevention; and (6) improve data collection and analysis.***

***The Task Force also developed goals to measure the success of activities:***
***• Reduce infant mortality rate to 6.0 per 1,000 live births by 2015;***
***• Reduce neonatal mortality rate to 4.1 per 1,000 live births by 2015;***
***• Reduce postneonatal mortality rate to 2.0 per 1,000 live births by 2015;***
***• Increase the percent of women who receive first trimester prenatal care to 77.8% by 2015; and***
***• Reduce the percent of women who smoke during pregnancy to 15% by 2015.***

***The recommendations and accompanying strategies of the Task Force are intended as a starting point for action by state government, health care providers, hospitals, tribes, parents, communities, and others to reduce infant mortality and improve infant health in South Dakota. A copy of the final report can be found at doh.sd.gov/InfantMortality/.***

***As a result of the recommendations of the task force, the South Dakota Cribs for Kids(r) program was established which is a public-private partnership aimed at assuring all infants born in South Dakota have a safe sleep environment. Through the Safe Sleep campaign, DOH field offices are addressing sleep environments with all families when they present for services by encouraging them to provide a safe sleep environment, offering information on safety features of cribs, bassinets, etc. Families with no resources for a safe bed for their baby receive a Pack N Play. To date, more than 140 cribs have been distributed to families in need of a safe sleep environment for their infants. In the coming months, a media campaign featuring the First Lady and focused on safe sleep for infants will also begin.***
***//2013//***

/2012/ The Director of the DOH Tobacco Control Program (TCP) sits on the steering committee of the Sacred Life Coalition, a part of GPTCHB Northern Plains Tribal Tobacco Technical Assistance Center. This coalition is committed to enhancing and increasing awareness for tobacco control and prevention for Native Americans in the Northern Plains by providing a forum for input, advocacy, education, collaboration, planning, and action along the commercial tobacco prevention continuum. This group of tribal and community stakeholders works to achieve all of their goals in a manner that values the importance of traditional tobacco use, and above all else, respect individual, tribal, and cultural differences. //2012//

***/2013/ In May, 2012, Governor Daugaard created a Primary Care Task Force to focus on potential expansion of the educational capacity of the state to train more primary health care providers for rural areas of South Dakota. The task force is co-chaired by a senior advisor to the Governor and the Dean of the USD Sanford School of Medicine and is comprised of medical and health professionals as well as policy makers. The task force will consider and make recommendations regarding the medical school class size, components of rural training tracks for medical students, residency programs in the state, and physician assistant and nurse practitioner education program capacity. The task force will also establish accountability measures to ensure any investment made helps promote access to primary care for all South Dakotans -- particularly in rural areas. The task force will meet throughout the summer and fall and report its recommendations to the Governor by December 15, 2012. //2013//***

***An attachment is included in this section. IIIA - Overview***

## B. Agency Capacity

The DOH is charged with the protection of the public health by appropriate measures set forth and authorized by state law. South Dakota Codified Law (SDCL) 34-1-21 designates the DOH as the sole state agency to receive, administer, and disburse federal Title V monies and authorizes the DOH to adopt rules to administer the Title V program relating to MCH and CSHS services. Administrative Rules of South Dakota (ARSD) 44:06 provides guidance on the delivery of services to CYSHCN and outlines general operation of the program, eligibility requirements, providers, family financial participation, claims, and scope of benefits. SDCL 34-24-18 requires all infants born in South Dakota to be screened for phenylketonuria (PKU), hypothyroidism, and galactosemia. ARSD 44:19 contains the rules regulating metabolic screening including screening for biotinidase deficiency, congenital adrenal hyperplasia, hemoglobinopathies, amino acid disorders fatty acid oxidation disorders, organic acid disorders, and cystic fibrosis.

The Division of Health and Medical Services (HMS) is the health care service delivery arm of the DOH and administers MCH services. HMS consists of three offices.

OFFICE OF FAMILY AND COMMUNITY HEALTH (OFCH) -- OFCH administers the MCH Block Grant for the DOH. OFCH provides leadership and technical assistance to assure systems that promote the health and well-being of women of reproductive age, infants, children, and youth, including those with special health care needs and their families. OFCH staff provide training and ongoing technical assistance to DOH field staff as well as private health care providers who deliver MCH services. Staff are responsible for the development of policies and procedures relevant to the delivery of MCH services for pregnant and postpartum women, infants, children, adolescents, and CYSHCN. OFCH works closely with field staff on data collection needed for federal and state reports as well as for program evaluation.

The CSHS program provides -- Health KiCC (Better Health for Kids with Chronic Conditions) -- provides financial assistance for medical appointments, procedures, treatments, medications, and travel reimbursement for children with certain chronic health conditions. Care coordination services are also available upon request. Health KiCC covers 100% of eligible covered expenses. If a person is eligible, Health KiCC covers the entire cost of the coverable services after other third party sources are billed. Assistance is limited to $20,000 per year.

The Perinatal program provides direction and technical assistance for primary and preventive care for women and infants including risk assessment and care coordination of pregnant women, perinatal education, prenatal/Bright Start home visits, and education on safe sleep.

The Newborn Metabolic Screening program helps identify babies who may have a metabolic disorder and alerts the baby's physician to the need for further testing and special care. In 2005, South Dakota expanded the number of mandated newborn disorders to be screened for to include 27 of the 29 American College of Medical Genetics (ACMG) report of core conditions. Of the ACMG report of secondary targets, South Dakota screens for 17 of the 25 deficiencies/ disorders. In addition, South Dakota screens for four deficiencies/disorders not listed on the ACMG report. Cystic fibrosis is also a mandated screen.

The Newborn Hearing Screening program works with hospitals to encourage screening of newborns for hearing loss prior to hospital discharge or by one month of age. The program also works to ensure health care providers and parents are informed about the benefits of early hearing screening and that follow-up is provided to infants referred for further hearing evaluation. The Newborn Hearing Screening program utilizes the Electronic Vital Records and Screening System (EVRSS) to determine which infants have been screened/not screened as well as which infants need rescreening and/or follow-up.

The WIC program promotes and maintains the health and well-being of nutritionally at-risk women, infants and children up to age five. Clients must meet income eligibility and be at nutritional risk. WIC provides nutrition education/counseling, breastfeeding support (i.e.,

information, breast pumps, breastfeeding peer counselors, etc.), healthy foods, referrals to health care providers and health/social services agencies, and immunizations (if needed).

South Dakota Family Planning (SDFP) offers men and women of childbearing age reproductive health education, contraceptive counseling and methods, physical examinations, and sexually transmitted disease (STD) counseling, testing and treatment. Payment for family planning services is based on a sliding fee schedule according to family size and income.

The Child/Adolescent Health program collaborates on a variety of activities designed to promote health, prevent disease and reduce morbidity and mortality among children and adolescents including abstinence, school health guidance, drug/alcohol prevention, rape prevention, and intentional/unintentional injury prevention.

Community health offices provide professional nursing and nutrition services and coordinate health-related services to individuals, families, and communities across the state. Services include education and referral, immunizations, developmental screenings, management of pregnant women, WIC, family planning, nutrition counseling/ education, and health screenings (i.e., blood pressure, blood sugar, vision, hearing, etc.). In most counties, these services are delivered at state DOH offices. In 11 Public Health Alliance sites, the office coordinates the delivery of services through contracts with local county governments and private health care providers.

OFCH also administers the Bright Start nurse home visiting program which is a community-based program in Sioux Falls, Rapid City, and Pine Ridge providing nurse home visiting services to high-risk families during pregnancy, after delivery, and continuing until the child's third birthday. The program focuses on high-risk pregnant mothers and new parents with limited economic and/or social and health resources. Ideally, the visits begin during the pregnancy but can begin whenever the family is referred to the program. Interventions include: (1) prenatal, maternal, and infant/child health assessments and education; (2) infant/child developmental assessments; (3) parenting education; (4) health, safety, and nutrition education; and (5) linking families with other resources in the community to maximize their overall functioning. The Bright Start home visiting program began in April 2000. In October 2008, one staff person was hired to begin providing Bright Start Home Visiting Service on the Pine Ridge Reservation. This allows the DOH to provide the program to pregnant women at Pine Ridge and allows for continuity of care for Native American women who are seen through the home visiting program in Rapid City and move between the Pine Ridge Reservation and Rapid City during their participation in the program. In FY 2009, 456 families were served by Bright Start.
/2012/ In FY2010, 583 families were served by Bright Start. //2012//
***/2013/ In FY2011, 471 families were served by Bright Start. //2013//***
The goal of the Bright Start program is to enhance the family's ability to care for itself and have a healthy baby. The program helps individuals and families identify strengths and assists the family utilize and build on these strengths and skills. The DOH is currently working with DSS, DOE, and others to complete the needs assessment required by the Patient Protection and Affordable Care Act of 2010.
/2012/ The DOH completed the required statewide needs assessment for the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHVP) in September and was awarded $635,083 to expand home visiting services to at-risk communities. Based on the findings of the needs assessment, Native American reservations around the state were identified as having the greatest need. The Pine Ridge Indian Reservation in the southwest corner of the state was identified as an area at the highest risk. Communities were considered to be at-risk based on the concentration of a number of factors such as: (1) premature birth, low birth weight infants, and infant mortality, including infant death due to neglect, or other indicators of at risk prenatal, maternal, newborn, or child health; (2) poverty; (3) crime; (4) domestic violence; (5) high rates of high-school dropouts; (6) substance abuse; (7) unemployment; and, (8) child maltreatment. The following at-risk communities are all located on or adjacent to Pine Ridge Indian Reservation - Kyle and Pine Ridge (Shannon County), Wanblee (Jackson County), and Martin (Bennett

County). OFCH has hired a Home Visiting Program Manager to assume management of the current Bright Start Home Visiting Program as well as oversee program implementation of the MIECHVP expansion to the Pine Ridge Indian Reservation area. //2012//
***/2013/ The DOH completed an updated state plan and application for 2011 funding and was awarded $1 million for additional expansion of the home visiting program. Establishing partnerships with tribal services and other resources that serve the early childhood populations has been an ongoing activity of the Home Visiting program manager. A site implementation plan was completed and approved for the Pine Ridge MIECHV expansion site. The nurse home visitors and site coordinator staff positions have not been filled at this time. The Sisseton-Wahpeton Reservation in the northeast corner of the State will be the next high-risk area targeted for home visiting. //2013//***

OFFICE OF HEALTH PROMOTION (OHP) -- OHP coordinates a variety of programs designed to promote health and prevent disease.

The All Women Count! (AWC) Breast and Cervical Cancer Control program coordinates statewide activities to promote early detection of breast and cervical cancer. Mammograms, Pap smears and related exams are available at no cost to eligible women at many physician offices, mammography units, family planning clinics, and other clinics throughout the state. AWC serves women (30-64 years of age for pap smears, 50-64 for mammograms) who are without insurance to pay for screening exams or who have insurance but cannot pay the deductible or co-payment.

The AWC Chronic Disease Screening program is an expansion of the Breast and Cervical Cancer program and includes cardiovascular and diabetes screening for eligible women enrolled in AWC. The expanded program reimburses health care providers for screening, diagnosis, and patient education for diabetes and cardiovascular disease. Women not only are screened for cardiovascular disease and diabetes but also can be seen by a professional for four physical activity and nutrition sessions per year.

The South Dakota Cancer Registry is a statewide population-based cancer registry that collects data on cancer incidence and reports on cancer incidence and mortality.

The Nutrition and Physical Activity program provides resources, technical assistance, and programs to a variety of target audiences such as parents and caregivers, schools/youth organizations, workplaces, communities, and health care providers to help prevent obesity and other chronic diseases. The Nutrition and Physical Activity program collaborates with many DOH programs to address poor nutrition and inadequate physical activity. With the help of a committed group of stakeholders, a "South Dakota State Plan for Nutrition and Physical Activity to Prevent Obesity and Other Chronic Diseases" was released in 2006. It was the first comprehensive plan to increase healthy eating and physical activity as ways to reduce overweight and obesity and their subsequent risk for chronic diseases such as cardiovascular disease, hypertension, and diabetes. The plan was updated and a revision released in April 2010. The full plan can be found on the healthy.sd.gov website.

The Coordinated School Health Program (CSHP) provides technical guidance and services to schools in the areas of nutrition, physical activity, and tobacco use. Its purpose is to expand and strengthen the capacity of state agencies and school districts to plan, carry out, and evaluate coordinated school health programs and address significant health problems that affect adolescents, especially HIV infection, tobacco use, sedentary lifestyle, and dietary habits that result in disease. The program is jointly administered with DOE.

The Diabetes Prevention and Control program designs, implements, and evaluates public health prevention and control strategies to improve access to, and quality of, diabetes education for all persons with diabetes in South Dakota, and delivers a broad range of public health activities to reduce death, disability and costs related to diabetes and its complications. In March 2010, the "South Dakota Diabetes State Plan 2010-2013" to reduce the impact of diabetes was released.

The plan was developed by individuals representing health care, advocacy groups, government agencies, tribal health, and quality improvement programs along with people who have diabetes and concerned family members. It details a wide range of activities for the next three years to reduce the impact of diabetes in South Dakota and improve the lives of those with the disease. The ultimate goal of the diabetes plan is to put in place a more effective system of early diagnosis, access to quality care, health promotion, and education so South Dakotans with this disease can live longer, healthier lives. A copy of the plan is available at http://doh.sd.gov/diabetes.

The Oral Health program coordinates activities to increase awareness of the importance of oral health and preventive care, foster community and statewide partnerships to promote oral health and improve access to dental care, and promote the use of innovative and cost effective approaches to oral health promotion and disease prevention. The program collaborates with numerous internal and external partners to address workforce issues, access to care, and reinforce disease prevention and dental education. In May 2009, 30 key stakeholders developed South Dakota's first ever State Oral Health Plan as a road map to provide guidance for achieving optimal oral health for all.

The Public Health Nutrition program is responsible for developing and managing nutrition activities for the DOH. The State Nutritionist serves as a spokesperson on issues that affect the nutritional health of the state and recommends appropriate nutrition interventions.

The TCP coordinates state efforts to prevent young people from starting to use tobacco products, help current tobacco users quit, and reduce non-smokers' exposure to secondhand smoke. /2012/ While smoking prevalence has decreased for many populations in South Dakota, Native Americans, Medicaid clients, pregnant women, spit tobacco users, and youth/young adults continue to use tobacco at much higher rates. The TCP will continue to assess tobacco use patterns, identify cessation needs and develop appropriate evidence-based strategies to develop and implement more effective interventions for these identified disparate populations. //2012//

***/2013/ In 2011, the DOH was awarded a community transformation grant (funded by American Recovery and Reinvestment Act funds) to promote wellness and facilitate policy and environmental changes related to physical activity, nutrition and tobacco. Funds have been used to promote increased physical activity, promote nutrition by limiting unhealthy food and drink for youth participating in non-school, youth sporting activities, and preventing the initiation of tobacco use among young people and eliminate non-smokers' exposure to secondhand smoke. //2013//***

OFFICE OF DISEASE PREVENTION (ODP) -- ODP coordinates infectious disease prevention and control programs. Within ODP, the Immunization Program provides vaccines for South Dakota's children to prevent such childhood diseases as measles, mumps, rubella, varicella, HiB, hepatitis B, and bacterial meningitis. The program also and provides recommendations and education on adult immunizations such as influenza, pneumonia and tetanus. The Immunization program provides vaccine materials, training, and support to both public and private immunization providers in the state and works in partnership with local and statewide coalitions. The South Dakota Immunization Information System (SDIIS) is a computerized software system that allows healthcare providers to share immunization records.

ODP staff investigate sources of STD infections, provide treatment and apply preventive measures to those exposed. Field offices provide confidential counseling and testing for HIV/ AIDS as well as educational materials, training for the public, schools and health care providers, and assistance with health care costs for those with HIV disease. The office provides TB clinics and contracts with the private medical sector for evaluation, treatment and follow-up of TB cases. ODP also conducts disease outbreak investigations in the state.

## C. Organizational Structure

The DOH is an executive-level department with the Secretary of Health appointed by, and reporting to, the Governor. The mission of the DOH is to prevent disease and promote health, ensure access to necessary, high quality care at a reasonable cost, and efficiently manage public health resources. As was noted earlier, SDCL 34-1-21 designates the DOH as the sole state agency to receive, administer and distribute federal Title V monies as well as adopt rules to administer the Title V program relating to MCH and CSHS.

The DOH is organized into three divisions -- Health and Medical Services, Administration and Health Systems Development and Regulation. The State Epidemiologist reports directly to the Secretary of Health. As was mentioned above, HMS is the health care service delivery arm of the DOH. A detailed description of HMS offices and activities is provided under "B. Agency Capacity".

The Division of Administration provides centralized support to DOH programs including financial management, computer systems, communications, health planning, legislative coordination, grant writing, health information technology, and research. The division also provides oversight of the state's correctional health care system. The Office of Data, Statistics and Vital Records (DSVR) provides technical assistance for the development, implementation, and evaluation of data collection activities. DSVR has an FTE to oversee data collection and analysis activities for the MCH block grant. DSVR maintains the vital records system for the state including births, deaths, marriages, divorces, and fetal deaths and issues certified copies of such records. The State Public Health Laboratory provides testing, consultation, and expert testimony in support of local, state and federal agencies and the general public.

The Division of Health Systems Development and Regulation administers regulatory programs related to health protection and health care facilities including the traditional public health areas of sanitation and safety, inspection and licensure of public facilities and Medicaid/Medicare survey and certification of health care facilities and providers. The Office of Rural Health (ORH) works to improve the delivery of health services to rural/medically underserved communities with an emphasis on access including recruitment of health professionals, technical assistance to health care facilities, development and use of telemedicine applications, and oversight of the South Dakota Trauma System. The Office of Public Health Preparedness and Response directs the state's bioterrorism/public health emergency response efforts. Past DOH preparedness funding has been used to strengthen the public health infrastructure in South Dakota including improvements in communication and computer systems for MCH field staff.

A copy of applicable DOH organizational charts are provided as an attachment to this section.

***An attachment is included in this section. IIIC - Organizational Structure***

## D. Other MCH Capacity

Preventive and primary care services to the MCH population are provided through OFCH. OFCH provides direction to state-employed nurses, nutrition educators, and dietitians for the provision of public health services in the state. Field staff providing primary preventive services for mothers, infants, and children include 6.3 FTE for mothers and infants and 8.8 FTE for children and adolescents. Another 8.3 FTE provide family planning services in the state.
/2012/ Field staff providing primary preventive services for mothers, infants, and children include 4.0 FTE for mothers and infants and 6.6 FTE for children and adolescents. Another 4.6 FTE provide family planning services in the state. //2012//
***/2013/ Field staff providing primary preventive services for mothers, infants, and children include 4.9 FTE for mothers and infants and 6.6 FTE for children and adolescents. Another 4.9 FTE provide family planning services in the state. //2013//***

OFCH and OCDPHP central office program staff dedicated to providing program direction to specific MCH program areas include: 1.39 FTE for child and adolescent health; 0.63 FTE for perinatal health; 2.2 FTE for family planning services; and 3.68 FTE for CSHS.
/2012/ OFCH and OCDPHP central office program staff dedicated to providing program direction to specific MCH program areas include: 1.3 FTE for child and adolescent health; 0.6 FTE for perinatal health; 2.3 FTE for family planning services; and 2.3 FTE for CSHS. //2012//
***/2013/ OFCH and OCDPHP central office program staff dedicated to providing program direction to specific MCH program areas include: 1.4 FTE for child and adolescent health; 0.4 FTE for perinatal health; 1.54 FTE for family planning services; and 2.2 FTE for CSHS. //2013//***

Darlene Bergeleen, RN, is the administrator of OFCH and serves as the MCH Program Administrator. Darlene has been with the DOH for 37 years and has served as the administrator of the former Office of Community Health Services for 10 years. Darlene has been actively involved in MCH block grant services in her years in the Office of Community Health and assumed the position of MCH Program Administrator in January 2010. Barb Hemmelman is the MCH Program Coordinator and serves as the CSHS Program Coordinator. Barb has been with the DOH since September 2004 and previously worked as the Director of the state's early intervention program within DOE Office of Special Education. Everett Putnam serves as the MCH State Data Contact and has been with the DOH since December 1988. Other MCH team members include the following:

- Linda Ahrendt , OHP Administrator
- Kristin Biskeborn, State Nutritionist
- Rhonda Buntrock, WIC Program Administrator
- Terry Disburg /2012/ Connie Bolte //2012// ***/2013/ Amanda Stednitz //2013//***, Sexual Violence Prevention Coordinator
- Bev Duffel, SDFP Program Administrator
- Julie Ellingson, Oral Health Coordinator
- Lucy Fossen, Newborn Metabolic/Hearing Screening Coordinator
- Lon Kightlinger, State Epidemiologist
- Jim McCord, Tobacco Control Program Administrator
- Anthony Nelson, Administrator, Office of Data, Statistics, and Vital Records ***/2013/ Mariah Pokorny, Vital Records -- State Registrar***
***/2012/ - Zach Parsons, Diabetes Control Program //2012//***
***- Josie Peterson, Office of Rural Health***
***- Colleen Reinert /2012/ Dee Dee Dugstad //2012//, Coordinated School Health Coordinator***
***- Peggy Seurer, Perinatal Nursing Consultant***
***- Susan Sporrer, Division of Administration***
***- Nato Tarkhashvilii, Epidemiologist***
***- Kelli Westley /2013/ Shelby Sampson///2013//***, Breastfeeding Coordinator
- Jenny Williams, Child and Adolescent Health Coordinator/CSHS Consultant
- Vacant /2012/ Mathew Christensen //2012//, Chronic Disease Epidemiologist, Data and Statistics Manager
/2012/ - Cheri Koch, Home Visiting Program Manager //2012//

Parent Connection identifies and recruits parents of CYSHCN to provide mentoring and peer support to other families with CYSHCN. They provide a family perspective to CSHS program staff regarding programs, policies and procedures, maintain a statewide database of support parents and groups, provide parent-to-parent training, and link parents throughout the state with trained supporting parents in a community-based manner. The MCH Program Coordinator serves on the advisory panel to assist in ongoing collaboration opportunities.

## E. State Agency Coordination

South Dakota's public health system includes the DOH, community health centers (CHCs), IHS, and tribal health representatives. While many states use local health departments to deliver public health services, in South Dakota these services are delivered by the DOH and funded primarily with federal or state resources. There is only one local health department in the state located in Sioux Falls. However, it primarily focuses on environmental health issues.

Representatives from the DOH and the Community HealthCare Association of the Dakotas (CHAD) continually explore ways to increase collaboration and coordination of health services such as MCH, family planning, community health, and infectious disease control. In some areas, DOH staff are co-located with CHCs. Where feasible, local DOH staff meet regularly with CHC staff to address identified needs and facilitate the development of a seamless system of care.

IHS delivers services to the Native American population on the state's nine reservations. There are IHS hospitals in Eagle Butte, Pine Ridge, Rapid City, Rosebud, and Sisseton. On many of the reservations, tribally-appointed community health representatives also provide services.

The DOH is a member of the South Dakota Kids Cabinet. The Kids Cabinet is authorized through a Governor's Executive Order and is comprised of Governor's Cabinet members and one designee from the DOH, DSS, DHS, DOE, and DOC. The mission of the Kids Cabinet is to maximize communication, collaboration, and cooperation among departments of state government serving children and their families and to improve the quality, quantity, and coordination of service delivery processes, programs, and systems. Key outcomes identified by the Kids Cabinet include: (1) children and youth remain at home with their families or within their communities whenever possible; (2) children enter school eager and ready to learn; and (3) children and youth are physically and mentally healthy. In addition to initiatives specific to early childhood education, youth in state custody, and development of systems of care for youth with serious emotional disturbances and their families, the Kids Cabinet has prioritized initiatives to decrease disparities in health, education, and social services for Native American children and youth.

The DOH and DSS have an interagency agreement to establish and assure referral mechanisms between agencies. The intent of the agreement is to maximize utilization of services and assure that services provided under Title V and Title XIX are consistent with the needs of recipients and that the objectives and requirements of the two programs are met. The agreement establishes procedures for early identification and referral of individuals under age 21 in need of services such as EPSDT, family planning, case management, and WIC. Representatives from both agencies meet regularly to discuss various issues including care coordination of high-risk pregnant women, referral mechanisms, outreach for Medicaid, and SCHIP.

The DOH has a number of information and referral mechanisms to assist in the identification and enrollment of eligible children for Medicaid services such as WIC, CSHS, community health nurses (CHNs), and Public Health Alliance (PHA). WIC facilitates referrals and links applicants with services so that families can access Medicaid as well as other health and social programs. In addition to the State program, there are three tribally-operated WIC programs on the Cheyenne River, Rosebud and Standing Rock Indian reservations. Coordination between the WIC and Medicaid program occurs as all Medicaid eligibility approvals of pregnant women are automatically reported to the WIC program on a weekly basis. CHN/PHA staff serve as an information and referral source to inform families of Medicaid availability and facilitate enrollment in Medicaid by referral. CSHS financial assistance process requires the family to also apply to Medicaid to ensure they are accessing all services that can be of assistance.

In CY 09, SDFP provided services to 2,858 adolescents under the age of 19. Of these, 1,083 were between the ages of 15-17; 10,063 of SDFP clients were females. In 2007, SDFP received funding to integrate HIV testing and prevention activities in family planning clinics. In CY 2006 (prior to the funding), 200 HIV tests were provided. In CY 2009, 1,596 HIV tests were provided. The goal is to assure everyone is aware of his or her HIV status as part of routine preventive

care. For the past three years, special funding has been available to increase the number of family planning users. As a result of this funding Sanford Downtown Healthcare in Sioux Falls has seen a 19.5% increase in the number of adolescent users and a 30% increase in the number of women under 150% of the FPL from 2008 to 2009. The Community Health Center of the Black Hills saw a 21% increase in the number of adolescent users and a 5% increase in the number of low income clients.
/2012/ In CY10, SDFP provided services to 2,697 adolescents under the age of 19. Of these, 1,067 were between the ages of 15-17; 9,601 of SDFP clients were females. Sanford Downtown Healthcare in Sioux Falls saw a 7.4% increase in the number of adolescents seen in the clinic. They have a dedicated community educator who provides community outreach and education in area middle and high schools. The community educator has also implemented sessions for students at one of the universities in Sioux Falls during which reproductive and preventive health care issues are discussed and questions answered. Since 2007, SDFP has received funding to integrate HIV testing and prevention activities in family planning clinics. In CY10, 2,120 HIV tests were provided to 2,073 unduplicated clients. The goal is to assure everyone is aware of his or her HIV status as part of routine preventive care. //2012//
***/2013/ In CY11, SDFP provided services to 2,446 adolescents under the age of 19. Of these, 971 were between the ages of 15-17. In 2011, 8,988 of SDFP clients were females. Since 2007, SDFP has received funding to integrate HIV testing and prevention activities in family planning clinics. In CY11, rapid HIV testing was provided to 671 adolescents 19 years of age and younger who were at increased risk due to lifestyles. HIV testing was also provided to 1,053 women aged 20-29 who had not previously been screened for HIV, sought other STD screening, and/or presented for pregnancy testing. //2013//***

In 2003, the South Dakota Legislature passed a concurrent resolution supporting the creation of a South Dakota plan for suicide prevention. The resolution recognized that suicide is a significant problem in South Dakota and declared that prevention of suicide be made a state priority by strengthening the private and public entities charged with addressing the problem. The overarching goals of the suicide plan include: (1) implementation of effective, research-based suicide prevention programs to reach the public and at-risk populations (i.e., elderly, Native Americans, youth/young adults, and rural communities); (2) provision of guidelines to schools for the development of effective suicide prevention programs; (3) development of public information campaigns designed to increase public knowledge of suicide prevention; (4) work with postsecondary institutions to develop effective clinical and professional education on suicide; (5) assurance that schools have effective linkages with mental health and substance abuse services; and (6) implementation of effective, comprehensive support programs for survivors of suicide.

The DOH collaborates with DSS to address issues affecting children and adolescents and their families such as suicide, tobacco use, FASD, and HIV prevention. DOH staff provide assistance and representation on the Division of Alcohol and Drug Abuse Advisory Council for Safe and Drug-Free Schools application reviews, Developmental Disabilities Council, and FASD Task Force.

DHS administers the state's Respite Care Program. The program is jointly funded with state general funds, MCH block grant funds, and some DHS federal grant funds. The Respite Care program offers services statewide. MCH block grant funds are expended to provide services for children on the program diagnosed with chronic medical conditions. CSHS program staff assist families with referral to the Respite Care Program. The program has an advisory group with representation from various state programs serving families who have children with special needs including special education, child protection, developmental disabilities, mental health, and CYSHCN. Parents are also represented on this group.

DOH is involved in an interagency agreement with DOE, DHS, and DSS to ensure collaboration in the maintenance and implementation of a statewide, comprehensive, coordinated, multidisciplinary, and interagency service delivery system for children eligible under Part C of the Individuals with Disabilities Education Act (IDEA). This system is designed to ensure the

availability and accessibility of early intervention services for all eligible infants and toddlers and their families. This agreement outlines the roles and responsibilities of the participating agencies related to the specific services required and provides guidance for their implementation.

South Dakota receives competitive grant funding from CDC for coordinated school health programming. Funding supports a collaborative relationship between the DOE and DOH in efforts to help local schools implement and coordinate school health programs directed towards the CDC priority areas of nutrition, physical activity, tobacco, and HIV. DOE and DOH have a Memorandum of Agreement outlining the responsibility and requirements to implement the program and have developed a very effective relationship that allows for maximum use of finances, staffing and resources. CSHP collaborates with GFP to offer the "Fantastic Field Trips" to teachers at no cost. Each teacher receives a packet of information including core content-based lessons and physical activity options while visiting the park. CSHP has provided funding to GFP to purchase snowshoes to enhance physical activity of youth and their families through the use of equipment that entices people to be more physically active.

South Dakota Schools Walk was started in 2003 in partnership between DOH and DOE to encourage students to become more physically active to help combat childhood obesity. Schools Walk is open to children of all ages but students in grades K-6 are eligible to receive incentives for their participation. South Dakota Schools Walk is a variation of the CDC program in that it focuses not only on kids walking/biking to school, but also kids walking while they are at school and for those attending After School Time Programs. The DOH continues to offer mini-grants to schools to support activities to improve nutrition and increase physical activity. These grants allow schools to use creative methods to address obesity in youth. In 2009-2010, South Dakota Schools Walk involved 4,276 K-6 grade students and 181 staff while the Schools Walk After School Program involved 810 K-6 grade students and 41 staff.

In 2004, Delta Dental of South Dakota partnered with Ronald McDonald House Charities to create the Ronald McDonald Care Mobile program in South Dakota. Delta Dental was granted a Ronald McDonald Care Mobile van with two fully equipped dental operatories to travel statewide to increase access to dental care in underserved areas of South Dakota. The strong demand for the Care Mobile prompted Delta Dental to expand the mobile dental program with the addition of a second truck -- the Smile Mobile -- utilizing funds from the John T. Vucurevich Foundation. Both the Care Mobile and the Smile Mobile operate under the program name "Delta Dental's Dakota Smiles Mobile Dental Program". The mission of the Dakota Smiles program is to treat children without access to dental care, which includes those children ages 0-21 who have not seen a dentist within the past two year and/or those that live more than 85 miles from a dentist. No child is turned away for inability to pay. Dental services provided include teeth cleaning, fillings for cavities, tooth extractions, dental sealants, fluoride treatments, instructions on care of teeth/gums, and tobacco/smoking cessation counseling. The Dakota Smiles program works with local site partners/sponsors who pay a site partner fee of $2,500 per week and who have the ability to identify and recruit patients who would otherwise have difficulty accessing dental services. Examples of past site partners have been Head Start agencies, Boys & Girls Clubs, United Way, Kiwanis, CHCs, hospitals, churches, local social services agencies, local service clubs, and schools. The care mobile typically spends a week in each community. The addition of a second unit enables the program to provide care for adults as well.

Since September 2004, the Dakota Smiles Mobile Dental Program has visited 65 communities across the state and served 11,388 children. Of those children, 50% were Medicaid/SCHIP enrolled and 43% were uninsured. To date, 67,430 diagnostic and preventive procedures and 21,645 restorative procedures have been completed. The retail dollar value of care provided is nearly $5 million.
/2012/ Since September 2004, the Dakota Smiles Mobile Dental Program has visited 68 communities across the state (including 12 Native American communities) and served 14,395 children and 422 adults. Of those children, 50 % were Medicaid/SCHIP enrolled and 43% were uninsured. To date, 86,270 diagnostic and preventive procedures and 27,686 restorative

procedures have been completed. The retail dollar value of care provided is $6,364,080. //2012// ***/2013/ Since September 2004, the Dakota Smiles Mobile Dental Program has visited 72 communities across the state (including 26 Native American communities) and served 17,367 children and 638 adults. Of those children, 50% were Medicaid/SCHIP enrolled and 43% were uninsured. To date, 104,814 diagnostic and preventive procedures and 35,315 restorative procedures have been completed. The retail dollar value of care provided is over $7.9 million. //2013//***

As a key partner with Delta Dental, the DOH has committed to staffing and coordinating services, as well as allocating resources to aid in providing oral health education, tobacco cessation, and assistance in maintaining a referral system for patients of the Dakota Smiles program. Providing primary dental care to children in these remote areas emphasizes the importance of preventive measures such as early intervention and continuing oral health education to reduce the prevalence of dental disease.

The DOH has a long-standing collaborative relationship with the Center for Disabilities within the USD School of Medicine's Department of Pediatrics. The South Dakota Leadership Education Excellence in Caring for Children with Neurodevelopmental and Related Disorders (LEND) is a program of the Center for Disabilities that works to improve the health status of infants, children, and adolescents with neurodevelopmental and related disabilities. The LEND program provides one year of specialized training focusing on the interdisciplinary training of professionals for leadership roles in the provision of health and related services to infants, children and adolescents with neurodevelopmental and related disabilities and their families. The program augments graduate studies in the disciplines of audiology, health administration, medicine, nursing, nutrition, speech-language pathology, occupational/physical therapy, pediatric dentistry, psychology, and public health social work. In addition to LEND, MCH and the Center for Disabilities collaborate on a number of training and other interagency projects.

In April 2008, DSS was awarded over $7.6 million in grant funds from the Centers for Medicare and Medicaid Services (CMS) to provide health care services in non-emergency room settings. South Dakota was one of 20 states to receive federal funding, receiving the largest award of all states and having the most projects funded. Projects supported by the grant are located in Martin, Mission, Pine Ridge, Wagner, Sioux Falls, and other South Dakota locations. The project focus is on providing access to non-emergency care to improve health outcomes and decrease the use of costly hospital emergency rooms. Grant funds are supporting health care staff recruitment, extended clinic hours, enhanced technology to link professionals to isolated communities, health education, chronic disease management clinics, and school-based health care services. Through the grant, a mobile medical clinic was built for the Pine Ridge Reservation. The mobile clinic provides a medical home for pregnant women and children up to age 21 on the Pine Ridge Reservation. The mobile clinic was used during H1N1 efforts to provide immunizations in communities on the Pine Ridge Reservation.

/2012/ The DOH, DPS Office of Emergency Medical Services (EMS), and the South Dakota Emergency Medical Technician Association (SDEMTA) joined forces to develop Simulation in Motion - South Dakota (SIM-SD) through grant funding provided by the Leona M. and Harry B. Helmsley Charitable Trust. SIM-SD is a one-of-a-kind mobile education program designed to bring this unique learning opportunity to pre-hospital and hospital emergency care providers in South Dakota. Grant funding was provided to Avera Health, Regional Health and Sanford Health to purchase, maintain and operate the mobile units. In central South Dakota, funding was provided to St. Mary's Healthcare Center in Pierre and Mobridge Regional Hospital to purchase and operate the outreach models. The units will include adult male, pregnant female, infant, and pediatric human patient simulators. SIM-SD allows providers who may only encounter a critically ill or injured patient once or twice a year the chance to encounter a similar ‘patient' multiple times with focused feedback in a managed stress environment. The benefits of the SIM-SD Program include: (1) accessible, hands-on training for pre-hospital and hospital personnel provided in their own communities; (2) enhanced team performance in critical care crisis management; (3) standardized curriculum to assure uniform educational opportunities; (4) access to state-of-the-art

equipment including life like human patient simulator mannequins; (5) a non-threatening learning environment where the mannequins simulate complex medical and trauma patients; (6) an opportunity for medical personnel to test and practice their critical thinking reactions and skills, leading to a high degree of familiarity and confidence; and (7) focused feedback in a low-stress environment. //2012//

MCH staff also serve on a variety of workgroups and advisory boards including Highway Safety Workgroup, Oral Health Advisory Board, Coordinated School Health Workgroup, Healthy South Dakota Workgroup, State Diabetes Coalition, Parent Connection Family to Family Advisory Council, Early Intervention Coordinating Council, and Developmental Disabilities Council, and Suicide Prevention.

## F. Health Systems Capacity Indicators

As was noted earlier, the MCH program works collaboratively with partners throughout the year on programs and strategies to improve the health of women, infants, children, adolescents, and CYSHCN. While specific activities/strategies and data interpretation information is provided under each individual Health Systems Capacity Indicator, one initiative of the MCH program this past year was focused on the development of the "I Didn't Know My Weight Matters" media campaign to increase awareness of the importance of appropriate weight gain during pregnancy.
***/2013/ Through the Safe Sleep campaign, DOH field offices are addressing sleep environments with all families when they present for services -- encouraging them to provide a safe sleep environment, offering information on safety features of cribs, bassinets, etc. Families with no resources for a safe bed for their baby receive a Pack N Play. To date, more than 140 cribs have been distributed to families in need of a safe sleep environment for their infants. In the coming months, a media campaign featuring the First Lady and focused on safe sleep for infants will also begin.//2013//***

The MCH program utilizes State Systems Development Initiative (SSDI) funding to access community hospital discharge data from the South Dakota Association of Healthcare Organizations (SDAHO) to address MCH performance measure. In addition, SSDI funds are used to conduct the Perinatal Health Risk Assessment Survey of new mothers to obtain data on behaviors and care/education received prior to, during, and post pregnancy. Data collected via the survey are used to address MCH performance measures.
***/2013/ In 2011, the DOH applied for funding for a statewide PRAMS project. The application was approved but not funded. A new Perinatal Health Risk Assessment Survey has not been conducted while the DOH explores other funding options for a statewide PRAMS.//2013//***

# IV. Priorities, Performance and Program Activities

## A. Background and Overview

The DOH priority needs are based on the needs assessment completed for the FY 2011-2015 needs assessment cycle. The South Dakota MCH five-year needs assessment provides an overview of the status of the priorities established by the MCH program as required by the Title V MCH Block Grant program. Priority needs in South Dakota cross the four levels of the public health services pyramid. The following priority needs in South Dakota cross the four levels of the public health services pyramid and are measured through both national and state performance measures:

• Reduce unintended pregnancies;
• Improve pregnancy outcomes;
• Reduce infant mortality;
• Reduce morbidity and mortality among children and adolescents;
• Improve adolescent health and reduce risk-taking behaviors (i.e., intentional and unintentional injuries, dietary habits, tobacco use, alcohol use, and other drug utilization);
• Reduce childhood obesity;
• Improve the health of, and services for, children with special health care needs (CSHCN) through comprehensive services and support;
• Improve and assure appropriate access to health services that are focused on families, women, infants, children, adolescents, and CSHCN; and
• Improve state and local surveillance and data collection and evaluation capacity.

The priority setting process is an ongoing and evolving process. Systems development for women, infants, children, adolescents, and CYSHCN is an integral part of the MCH planning process and includes analyzing current programs and services, identifying gaps in services, establishing appropriate goals and objectives, collaborating with partners, and establishing methods for monitoring and evaluating programs and services to ensure that goals and objectives are met.

The MCH team also initiated a MCH Assessment, Planning and Monitoring Process which is data driven, with the starting point of assessing the needs of the MCH population groups using Title V health status and system capacity indicators, performance measures, and other quantitative and qualitative data. The process focused on needs, priorities, targets, and activities -- not specific programs or individuals. The team discussed national and state performance measures, determining if objectives were met or unmet. Health system capacity, health status indicators, and data sets used were analyzed. Additional data sources to assist in assessment of each population group were identified. As a result of this process, state performance measures were identified. The MCH program utilized focus groups to gather additional input.

## B. State Priorities

As a result of the MCH assessment, South Dakota has developed eight performance measures that relate directly to identified priority needs. Priority needs in South Dakota, as well as the respective performance measures and activities that address these needs, cross the four levels of the core public health infrastructure pyramid -- direct services, enabling services, population-based services, and infrastructure building services.

Direct service interventions improve health status and reduce adverse outcomes. Since enabling services facilitate and enhance direct services, activities in both levels of the pyramid will address the state's priorities. There are several priority needs that primarily impact the population-based service level. In order to accomplish improvement in the state's priorities, there must be education and service interventions at both the direct and enabling service levels. Conversely, effective

interventions at the direct and enabling service levels require population-based education and other activities. All state priority needs have elements of infrastructure building services. The development of an interagency collaborative infrastructure is critical to reducing barriers to care and improving health outcomes. Improved state and local surveillance, data collection and evaluation capacity facilitate data-driven decision making regarding allocation or resources and strategies to address the priority needs. Coordination, quality assurance, standards development, and monitoring must accompany interventions to reduce barriers to care and improve and assure appropriate access to health services focused on families, women, infants, children, adolescents, and CYSHCN.

For the 2011-2015 needs assessment cycle, South Dakota has selected the following state performance measures:

SPM #1: Percent of pregnancies which are unintended (mistimed or unwanted) and result in live birth or abortion.
Unintended pregnancies are associated with maternal health risk behaviors, low use of preventive health measures (i.e., early prenatal care), child abuse, and dependency on welfare. There is a greater risk for complications and poor pregnancy outcomes including infant mortality, birth defects, and low birth weight infants.

SPM #2: Percent of singleton birth mothers who achieve a recommended weight gain during pregnancy.
Gestational weight gain is an important determinant of fetal growth. Inadequate weight gain increases risk of inadequate fetal growth, low birth weight, and infant death. Excessive weight gain increases risk of excessive fetal growth leading to increased incidence of C-section. Risk of maternal complications such as hypertension are also increased. Maternal weight gain is susceptible to intervention and represents an avenue for prevention of poor birth outcomes. A woman with a normal BMI should gain 29 to 40 pounds; and those with a high BMI should gain 15 to 25 pounds. Excessive weight gain also is often retained by the mother thus contributing to adult obesity and high BMI for subsequent pregnancies.

SPM #3: Percent of pregnant women aged 18-24 who smoked during pregnancy.
Smoking during pregnancy is estimated to account for 20 to 30 percent of low birth weight babies and about 10 percent of all infant deaths. Smoking during pregnancy can cause the baby to have more colds, lung problems, learning disabilities, and physical growth problems.

SPM #4: Percent of infants exposed to secondhand smoke.
Infants exposed to secondhand smoke are at increased risk for developing respiratory infections, allergies, asthma, digestive difficulties, and SIDS.

SPM #5: Percent of WIC infants breastfed at 6 months of age.
Both babies and mothers gain benefits from breastfeeding. Breast milk is easy to digest and contains antibodies that can protect infants from bacterial and viral infections. In addition, research suggests breastfeeding decreases obesity in childhood and later in life.
***/2013/ This state performance measure has been discontinued as there is no way to remove WIC only data from the statewide data. //2013//***

SPM #6: Percent of school-aged children and adolescents with a Body Mass Index (BMI) at or above the 95th percentile.
Obesity is a risk factor for many chronic medical conditions including cardiovascular disease, hypertension, diabetes, degenerative joint disease, and psychological problems. Overweight can result from excessive energy intake, decreased energy expenditure, or impaired regulation of energy metabolism.

SPM #7: Percent of high school youth who self-report tobacco use in the past 30 days.
Smoking is responsible for one in six adult deaths in the U.S. and is the single most preventable

cause of death.

SPM #8: Accidental death rate among adolescents aged 15-19 year old.
South Dakota's teen accidental death rate is almost double the national average. The leading causes of accidental deaths -- motor vehicle crashes and suicide -- can both be prevented.

South Dakota's State Outcome Measure addresses the Native American infant mortality rate for the state. The infant mortality rate is a traditional indicator of general health status. Native American infant mortality has been a long standing public health problem. Using a five-year rolling average, the discrepancy in Native American and white infant mortality has decreased over the past five years from 2.7 in 2004 to 2.2 in 2009 while overall infant mortality rates for the state have decreased from 8.2 to 6.7.

## C. National Performance Measures

**Performance Measure 01:** *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2007** | **2008** | **2009** | **2010** | **2011** |
|---|---|---|---|---|---|
| Annual Performance Objective | 100 | 100 | 100 | 100 | 100 |
| Annual Indicator | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |
| Numerator | 11 | 14 | 24 | 20 | 18 |
| Denominator | 11 | 14 | 24 | 20 | 18 |
| Data Source | | Metabolic Screening Program | Metabolic Screening Program | Metabolic Screening Program | Metabolic Screening Program |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2012** | **2013** | **2014** | **2015** | **2016** |
| Annual Performance Objective | 100 | 100 | 100 | 100 | 100 |

**Notes - 2011**
2009-2011 South Dakota Metabolic Screening program data. Numerator and denominator are 3-year averages. Includes only resident confirmed cases. South Dakota law mandates all confirmed positive screens receive appropriate follow-up.

**Notes - 2010**

2010 South Dakota Metabolic Screening Program state resident data. The 2006-2010 five-year trend of the percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for. condition(s) mandated by their State-sponsored newborn screening programs shows a flat trend with no deviations over the years. The data for this measure were collected by the South Dakota Metabolic Screening Program. Due to small numbers, 3-year averages were used in the 2006-2008 analysis.

**Notes - 2009**
2007-2009 South Dakota Metabolic Screening Program data. Numerator and denominator are 3-year averages. Includes only resident confirmed cases. South Dakota law mandates all confirmed positive screens receive appropriate follow-up.

**a. Last Year's Accomplishments**
• Partnered with State Hygienic Laboratory of Iowa (SHL) for the provision of newborn metabolic screening laboratory services in South Dakota for all mandated disorders including congenital hypothyroidism, galactosemia, PKU, hemoglobinopathies, biotinidase deficiency, congenital adrenal hyperplasia, amino acid disorders, fatty acid oxidation disorders, organic acidemias, and cystic fibrosis.

• Provided ongoing technical assistance to hospitals/physician offices regarding process changes in newborn screening procedures with SHL.

• Collaborated with SHL and health care providers to assure follow-up on infants with indeterminate or abnormal specimens as well as infants with borderline or presumptive positive test results.

• Collaborated with DSVR to link birth certificates with laboratory results through EVRSS for data collection and monitoring.

• Identified infants without metabolic screening results through ongoing matching of birth certificates and laboratory reports and provided follow-up to ensure infants received a newborn screening.

• Updated program follow-up protocols to assure appropriate notifications and medical management of infants with positive screening results.

• Utilized the SHL website to monitor indicators of quality such as turnaround times and poor quality specimens.

• Updated information links and resources on the DOH Newborn Screening website.

• Participated on the Heartland Regional Genetics and Newborn Screening Collaborative to identify regional needs and improve access to newborn screening services.

**Table 4a, National Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Maintain/improve newborn metabolic screening data collection system. | | | | X |
| 2. Screen/provide necessary follow-up for required disorders. | | | X | |
| 3. Verify notification of indeterminate and abnormal test results. | X | | | |
| 4. Distribute newborn metabolic screening program brochure to healthcare providers. | | | X | |
| 5. Update program manual as necessary and distribute to | | | | X |

| | | | | |
|---|---|---|---|---|
| hospitals and healthcare providers in the state. | | | | |
| 6. Maintain and update newborn screening program website. | | | | X |
| 7. Refer infants diagnosed with a metabolic disorder to CYSHCN program. | | | | X |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

• Partnering with SHL for the provision of newborn metabolic screening laboratory services.

• Working with SHL toward implementation of Severe Combined Immunodeficiency (SCID) screening.

• Collaborating with SHL and health care providers to assure follow-up on infants with borderline or presumptive positive test results.

• Linking birth certificates with laboratory results through the EVRSS for data collection and monitoring.

• Working with medical specialists to assure appropriate follow-up and medical management of infants with positive screening results.

• Utilizing SHL website to monitor indicators of quality (i.e., turnaround times and poor quality specimens).

• Collaborating with the Heartland Regional Genetics and Newborn Screening Collaborative to identify regional needs to improve access to newborn screening services.

• Facilitating a SCID workgroup meeting of newborn screening stakeholders to evaluate, assess and develop strategies toward implementation of SCID screening.

• Working with public health nurses and community health representatives on Native American reservations to locate infants needing additional testing.

• LTFU identifying high risk infants who are at risk of not receiving appropriate care and medical management by a specialist.

• LTFU linking families to financial assistance and medical management resources.

• Mailing LTFU questionnaire to parents and providers annually to track the health and development of infants with identified disorder.

**c. Plan for the Coming Year**

• Partner with SHL for the provision of newborn metabolic screening laboratory services in South Dakota for all mandated disorders.

• Provide technical assistance to hospitals and physician offices regarding process changes in newborn screening procedures with SHL.

• Collaborate with SHL and health care providers to assure follow-up on infants with borderline and abnormal screening test results.

• Provide follow-up to those infants without metabolic screening results through ongoing matching of birth certificates and laboratory reports.

• Strengthen relationships with medical specialists to assure appropriate follow-up and medical management for infants with positive screening results.

• Utilize SHL website to monitor indicators of quality such as turnaround times and poor quality specimens.

• Collaborate with the Heartland Regional Genetics and Newborn Screening Collaborative to identify regional needs to improve access to newborn screening services.

• Update information links and resources on the DOH Newborn Screening website.

• Send quality assurance reports to submitting facilities comparing unacceptable specimen rates and turnaournd times with state averages.

• Work with public health nurses and community health representatives on the reservations to locate infants needing additional testing.

• Continue LTFU efforts to identify infants not receiving appropriate care and medical management.

• Participatie in tri-state (ND, SD, IA) conference call with metabolic specialists to conduct case review.

• Link families to financial assistance and medical management resources.

• Mail annual LTFU questionnaire to parents and providers to track the health and development of infants with identified disorder.

## Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

| **Total Births by Occurrence:** | **12470** | | | | | |
|---|---|---|---|---|---|---|
| **Reporting Year:** | **2011** | | | | | |
| **Type of Screening Tests:** | **(A) Receiving at least one Screen (1)** | | **(B) No. of Presumptive Positive Screens** | **(C) No. Confirmed Cases (2)** | **(D) Needing Treatment that Received Treatment (3)** | |
| | No. | % | No. | No. | No. | % |
| Phenylketonuria (Classical) | | 0.0 | | | | |
| Congenital Hypothyroidism (Classical) | 12411 | 99.5 | 35 | 3 | 3 | 100.0 |
| Galactosemia | 12411 | 99.5 | 1 | 0 | 0 | |

| | | | | | | |
|---|---|---|---|---|---|---|
| (Classical) | | | | | | |
| Sickle Cell Disease | 12411 | 99.5 | 0 | 0 | 0 | |
| Biotinidase Deficiency | 12411 | 99.5 | 10 | 0 | 0 | |
| Cystic Fibrosis | 12411 | 99.5 | 14 | 2 | 2 | 100.0 |
| 21-Hydroxylase Deficient Congenital Adrenal Hyperplasia | 12411 | 99.5 | 3 | 1 | 1 | 100.0 |
| Amino Acid and Acylcarnitine | 12411 | 99.5 | 159 | 3 | 3 | 100.0 |
| Congenital Adrenal Hyperplasia | 0 | | 0 | 1 | 1 | 100.0 |
| Biotinidase | 0 | | 0 | 5 | 5 | 100.0 |
| Congenital Hypothyroidism | 0 | | 0 | 64 | 63 | 98.4 |
| Galactosemia | 0 | | 0 | 3 | 3 | 100.0 |
| Amino Acid and Acylcarnitine | 0 | | 0 | 55 | 54 | 98.2 |
| Sickle Cell Disease/Hemoglobinopathies | 0 | | 0 | 10 | 10 | 100.0 |

**Performance Measure 02:** *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2007** | **2008** | **2009** | **2010** | **2011** |
|---|---|---|---|---|---|
| Annual Performance Objective | 96 | 98.5 | 97 | 97.8 | 97.8 |
| Annual Indicator | 98.5 | 96.4 | 97.8 | 63.4 | 69.7 |
| Numerator | 15977 | 15950 | 12826 | 14772 | 16784 |
| Denominator | 16226 | 16554 | 13114 | 23295 | 24087 |
| Data Source | | BRFSS | BRFSS | National Survey of CSHCN | National Survey of CSHCN |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2012** | **2013** | **2014** | **2015** | **2016** |
| Annual Performance Objective | 75 | 75.5 | 75.5 | 75.5 | 75.5 |

**Notes - 2011**
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as

survey design flaws, respondent classification and reporting errors, and data processing mistakes.

**Notes - 2010**
Data from 2005-2006 National Survey of Children with Special Health Care Needs

**Notes - 2009**
2009 South Dakota BRFSS survey weighted data

**a. Last Year's Accomplishments**
• Shared resources for families regarding support groups and transition planning resources.

• Collaborated with SDPC who provides information, resources, and individual assistance and training via DDN, webinar, and in-person workshops to teach and empower families to partner with professionals to ensure child and family needs are met to their satisfaction. From October 1, 2010 through September 30, 2011, SDPC served 900 unduplicated families from across South Dakota. SDPC is the sole distributor of the FILE (Folder of Information and Life Experiences) record keeping system for families of CYSNCH with over 8,000 FILEs distributed. Families receive FILEs directly from SDPC or via SDPC partnerships with the early intervention program, family support providers, and NICU staff at the three largest hospitals in the state.

• Data from follow-up survey for June 2010 through May 2011 indicated 90% of families assisted and/or trained by SDPC reported they were better able to partner in decision-making.

**Table 4a, National Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Collaborate on activities to support/empower parents. | | X | | |
| 2. Identify training opportunities for families. | | X | | |
| 3. Request public input prior to any administrative rules revisions impacting child/ family involvement in the CSHS program. | | | | X |
| 4. Maintain LTFU metabolic program | | X | | |
| 5. Financially support SDPC work with CYSHCN | | X | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**
• Identifying and sharing new resources for families including support groups and transition planning resources.

• Collaborating with SDPC on parent training opportunities, FILE, Family to Family contacts, and other activities to support families.

• Strengthening relationships with medical specialists to assure appropriate follow-up and medical management for infants with positive newborn metabolic screening results.

• Continuing LTFU program to include children residing in South Dakota identified with metabolic disorders; 150 children are not being tracked via LTFU.

• Representing DOH on various advisory councils that assist families in accessing services

including the state's early intervention program, Diabetes Coalition, Developmental Disabilities Council, and SDPC Family to Family Advisory Council.

• Supporting the South Dakota Board of Nursing (BON) Virtual Nursing Care for Children with Diabetes in the School Setting project which utilizes a model of virtual nurse delegation/supervision of trained unlicensed individuals caring for school children with diabetes, including administration of insulin. The project is currently working with 29 children in 19 different schools.

• Providing the services of translators for non-English speaking families.

• Working with Bright Start Nurse Home Visiting program to assist eligible recipients find/access supportive community resources/services; nurse home visiting programs are offered in three sites in the state including one reservation

**c. Plan for the Coming Year**

• Financially support SDPC work to enhance opportunities and resources for families.

• Promote community training opportunities for families and providers on decision making and medical/home partnerships.

• Serve as an ad hoc member of the SDPC Family to Family Advisory Committee.

• Continue LTFU program and have annual contact with parents/caregivers to assess their needs as well as with primary care providers and/or specialty physician to ensure ongoing care.

• Continue support of BON Virtual Nursing Care for Children with Diabetes project.

• Obtain services of translators for non-English speaking families.

• Work with Bright Start Nurse Home Visiting program to educate and support eligible recipients.

**Performance Measure 03:** *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2007** | **2008** | **2009** | **2010** | **2011** |
|---|---|---|---|---|---|
| Annual Performance Objective | 91 | 97.3 | 97.3 | 97.4 | 97.4 |
| Annual Indicator | 97.3 | 97.3 | 96.7 | 53.8 | 42.2 |
| Numerator | 16631 | 14820 | 11476 | 12184 | 9962 |
| Denominator | 17099 | 15226 | 11869 | 22652 | 23585 |
| Data Source | | BRFSS | BRFSS | National Survey of CSHCN | National Survey of CSHCN |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2012** | **2013** | **2014** | **2015** | **2016** |
| Annual Performance Objective | 50 | 50 | 50 | 50 | 50 |

**Notes - 2011**
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

**Notes - 2010**
Data from 2005-2006 National Survey of Children with Special Health Care Needs

**Notes - 2009**
2009 South Dakota BRFSS survey weighted data.

**a. Last Year's Accomplishments**
• Networked with providers and families to address services and assistance available under CSHS.

• Provided care coordination and financial assistance to children with chronic medical conditions and their families through CSHS.

• Collaborated with SDPC who provided individual assistance to families of CYSHCN to connect them to medical and dental services/supports, including telephone, via e-mail, distribution of informational materials, and electronic distribution of information and resources via SDPC website and publications. SDPC provided individual assistance to professionals serving CYSHCN to connect families to physical, mental, and dental health services/supports. This includes over the telephone, via e-mail, and in person distribution of thousands of informational materials at community events, conferences, and trainings, and electronic distribution of information and resources via SDPC website and publications. From October 1, 2010 through September 30, 2011, SDPC served 1,190 professionals from across South Dakota.

**Table 4a, National Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Provide care coordination services to children with chronic medical conditions. | | X | | |
| 2. Network with providers and families on provision of services. | | | | X |
| 3. Provide financial assistance for medical and mileage expenses to ensure comprehensive care. | | X | | |
| 4. Financially support SDPC's activities/resources for families of CYSHCN. | | X | | |
| 5. | | | | |

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|---|---|---|---|---|
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

• Maintaining e-mail address and website for families to access assistance via the internet.

• Networking with providers and families to address services/assistance available under CSHS.

• Continuing collaborative efforts with SDPC.

• Strengthening relationships with medical specialists to assure appropriate follow-up and medical management for infants with positive newborn metabolic screening results.

• Expanding LTFU program to include all children residing in South Dakota identified with metabolic disorders; 150 children are being tracked via LTFU.

• Representing DOH on various advisory councils that assist families access services.

• Supporting the BON Virtual Nursing Care for Children with Diabetes in the School Setting project which utilizes a model of virtual nurse delegation/supervision of trained unlicensed individuals caring for school children with diabetes, including administration of insulin. The project is currently working with 29 children in 19 different schools.

• Supporting expansion of primary and specialty care services to minimize travel time and missed work/school days.

• Contracting for the provision of genetic outreach services in three locations in the state.

• Working with Bright Start Nurse Home Visiting program to assist eligible recipients find/access supportive community resources/services; nurse home visiting programs are offered in three sites in the state including one reservation.

**c. Plan for the Coming Year**

• Provide financial assistance for medical and mileage expenses to appointments to ensure ongoing, comprehensive care.

• Provide care coordination services to children with chronic medical conditions.

• Network with providers and families to address services and assistance available under CSHS.

• Maintain e-mail access and website.

• Continue LTFU program and have annual contact with parents/caregivers to assess their needs as well as with primary care providers and/or specialty physicians to ensure ongoing care.

• Collaborate with community programs to identify available community resources for families.

• Maintain DOH representation on various advisory councils that assist families access services.

• Continue collaborative efforts with SDPC.

• Continue contract for the provision of genetic outreach services.

**Performance Measure 04:** *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2007** | **2008** | **2009** | **2010** | **2011** |
|---|---|---|---|---|---|
| Annual Performance Objective | 69 | 89.7 | 91 | 91.5 | 91.5 |
| Annual Indicator | 89.6 | 91.0 | 91.4 | 66.7 | 62.4 |
| Numerator | 16040 | 16622 | 13484 | 15527 | 14753 |
| Denominator | 17900 | 18267 | 14749 | 23294 | 23631 |
| Data Source | | BRFSS | BRFSS | National Survey of CSHCN | National Survey of CSHCN |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2012** | **2013** | **2014** | **2015** | **2016** |
| Annual Performance Objective | 65 | 65 | 65 | 65 | 65 |

**Notes - 2011**
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

**Notes - 2010**
Data from 2005-2006 National Survey of Children with Special Health Care Needs

**Notes - 2009**
2009 South Dakota BRFSS survey weighted data.

**a. Last Year's Accomplishments**
• Assisted in identification and referral of CYSHCN and their families and facilitated application to Medicaid, SCHIP, and SSI as appropriate.

• Provided care coordination and financial assistance to children with chronic medical conditions and their families.

• SDPC developed training "Accessing Services and Supports" which has been delivered at the

statewide Parent Education Series training, tri-state Lighting the Way Autism conference, and the statewide Community-Based Child Abuse Prevention Advisory Board meeting. The training was recorded and made available for online viewing.

• SDOC provided meeting room and technology for a national webinar of IHS conducted by the national Parent Training Information Center serving Native American families.

**Table 4a, National Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Provide financial assistance for services for CYSHCN. | | X | | |
| 2. Assist in the identification and referral of CSHCN and their families and facilitate their application to Medicaid, SCHIP, and SSI. | | X | | |
| 3. Identify new assistance programs available for families. | | | | X |
| 4. Financially support SDPC and transition planning and insurance coverage activities. | | X | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

• Providing financial assistance for services for CYSHCN up to 250% of FPL and no cost share with all eligible families receiving 100% coverage after all other third party payers.

• Assisting in identification and referral of CYSHCN and their families and facilitating application to Medicaid, SCHIP, and SSI as appropriate.

• Linking families to other resources that can assist with needs not being met by their public or private health care coverage (i.e., prescription assistance, community-specific assistance programs).

• Ensuring staff are aware of assistance programs available to families such as the SD Risk Pool (insurance for individuals who have lost insurance coverage through no fault of their own), Respite Care Program, Family Support Services, and Birth to 3 Connections (early intervention program).

• Collaborating with SDPC who provides individual assistance to families of CYSHCN and professionals serving this population to provide information to link families to financial support programs (i.e., Medicaid, SCHIP, Health KiCC, Family Support 360, Shriners, etc.).

• Attended an employment and benefits workshop in order to present accurate information on social security, Medicaid, and Medicare benefits.

• Linking CSHS families to providers who are participating and have agreed to CSHS reimbursement rates.

• Provided information to families on the Affordable Care Act and changes in insurance coverage for pre-existing health conditions.

**c. Plan for the Coming Year**

• Collaborate with DHS and SSA to facilitate action on transmittals from Disability Determination Services.

• Collaborate with DHS (Divisions of Developmental Disabilities, and Vocational Rehabilitation), Social Security Administration (SSA), DSS (Medicaid, SCHIP, Behavioral Health Services), and DOE (Birth to 3) to assist in the provision of coverage and services for CYSHCN.

• Identify possible assistance programs/resources available across the state.

• Continue collaborative activities with SDPC.

• Link CSHS families to providers who are participating and have agreed to CSHS reimbursement rates.

**Performance Measure 05:** *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2007** | **2008** | **2009** | **2010** | **2011** |
|---|---|---|---|---|---|
| Annual Performance Objective | 76 | 88.3 | 94.3 | 94.5 | 94.5 |
| Annual Indicator | 88.0 | 94.3 | 92.9 | 90.4 | 64.9 |
| Numerator | 13496 | 14097 | 10625 | 21117 | 15711 |
| Denominator | 15333 | 14955 | 11433 | 23353 | 24218 |
| Data Source | | BRFSS | BRFSS | National Survey of CSHCN | National Survey of CSHCN |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2012** | **2013** | **2014** | **2015** | **2016** |
| Annual Performance Objective | 70 | 70 | 70 | 70 | 70 |

**Notes - 2011**

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as

survey design flaws, respondent classification and reporting errors, and data processing mistakes.

**Notes - 2010**
Data from 2005-2006 National Survey of Children with Special Health Care Needs

**Notes - 2009**
2009 South Dakota BRFSS survey weighted data.

**a. Last Year's Accomplishments**
• Provided care coordination and financial assistance to children with chronic medical conditions and their families through CSHS.

• Received referrals from physicians, schools, parents, hospitals, and other agencies.

• Assisted in the provision of needed services for specialty care and/or primary care follow-up for CYSHCN in their home community.

• Contracted for the provision of genetic outreach services in three locations in the state.

• SDPC provided individual assistance and training to families and providers at Pine Ridge, Rosebud, Crow Creek, Sisseton-Wahpeton, and Cheyenne River tribal reservations..

• SDPC follow-up survey data from July 2010 to May 2011 indicated 96% of families assisted/trained by SDPC reported being better able to find and/or learn about community services.

• Provided financial support to the State's Respite Care program which was able to serve 756 families.

**Table 4a, National Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Continue to improve coordination of care for CYSHCN. | | | | X |
| 2. Continue networking efforts to ensure awareness of CSHS. | | | | X |
| 3. Provide care coordination services to children with chronic medical conditions. | | X | | |
| 4. Contract for genetics outreach clinics. | X | | | |
| 5. Financially assist the state’s respite care program. | | | | X |
| 6. Financially support SDPC activities. | | X | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**
• Improving coordination of care by establishing linkages with other agencies, programs, and providers via conferences, task forces, workgroups, and program planning committees.

• Providing care coordination, clinical services, and/or financial assistance to children with chronic medical conditions and their families through CSHS.

• Receiving referrals from physicians, schools, parents, hospitals, and other agencies.

• Assisting in the provision of needed services for specialty care and/or primary care follow-up for CYSHCN in their home community.

• Providing e-mail address for families to access assistance via the internet and enhancing www.children.sd.gov website to include application package.

• Representing DOH on various advisory councils that assist families access services including the state's early intervention program, Diabetes Coalition, Developmental Disabilities Council, and SDPC Family to Family Advisory Council.

• Supporting the expansion of primary and specialty care services to minimize travel time and missed work/school days.

• Contracting for the provision of genetic outreach services in three locations in the state.

• Supporting the Dare to Dream Conference which is a statewide, biannual conference for families.

• Continuing interagency agreement with DHS to implement the Respite Care program.

**c. Plan for the Coming Year**

• Develop and implement new media strategies to address CSHS changes including increased financial assistance with family income now up to 250% of FPL and no cost share.

• Communicate with all medical providers so they are aware of CSHS program and the services/assistance available to their patients.

• Continue to collaborate with SDPC.

• Reemphasize the role of the primary care provider in the care of the CYSHCN population regarding the medical home, coordination of care, and needed communication between all providers.

• Maintain e-mail access and website.

• Continue LTFU program and have annual contact with parents/caregivers to assess their needs as well as with primary care providers and/or specialty physicians to ensure ongoing care.

• Collaborate with community programs to identify available community resources for families.

• Maintain DOH representation on various advisory councils that assist families access services.

• Continue contract for genetics outreach services.

• Continue interagency agreement with DHS to implement the Respite Care program.

**Performance Measure 06:** *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2007 | 2008 | 2009 | 2010 | 2011 |
|---|---|---|---|---|---|
| Annual Performance Objective | 55 | 86.2 | 86.9 | 96.2 | 85 |
| Annual Indicator | 86.2 | 86.9 | 96.2 | 50.6 | 48.3 |
| Numerator | 5434 | 4202 | 4408 | 4353 | 4918 |
| Denominator | 6307 | 4836 | 4584 | 8607 | 10177 |
| Data Source | | BRFSS | BRFSS | National Survey of CSHCN | National Survey of CSHCN |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2012** | **2013** | **2014** | **2015** | **2016** |
| Annual Performance Objective | 55 | 55.5 | 56 | 56.5 | 56.5 |

**Notes - 2011**
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

**Notes - 2010**
Data from 2005-2006 National Survey of Children with Speical Health Care Needs

**Notes - 2009**
2009 South Dakota BRFSS survey weighted data.

**a. Last Year's Accomplishments**
• Provided care coordination and financial assistance to children with chronic medical conditions and their families through CSHS.

• Collaborated with SDPC staff who serve on various boards and committees that address transition issues such as the SD Board of Vocational Rehabilitation and the Sioux Falls Area Interagency Transition Council.

**Table 4a, National Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |

| | | | | |
|---|---|---|---|---|
| 1. Assist adolescent CYSHCN identify/address needs related to transition to adult life. | | X | | |
| 2. Financially support SDPC to continue to address transition activities for CYSHCN. | | X | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

• Assisting adolescent CYSHCN and their families prior to age 18 identify areas of need related to transition to all aspects of adult life through care coordination activities and resource identification. The CSHS program works with CYSHCN and their families up to the child's 21st birthday.

• Representing the DOH on various advisory councils that assist families access services including the state's early intervention program, Diabetes Coalition, and Developmental Disabilities Council.

• Promoting SDPC partners with Independent Living Choices (ILC) to provide training and information to families and youth enrolled in summer programs for high school youth with disabilities to prepare them for the transition from high school to the adult world. SDPC also provides service learning projects for youth involved in ILC programs.

• Promote Youth Leadership Forum, a weekend long experience for youth to teach self-advocacy and leadership skills, as well as multiple transition forums and evens for students and their families.

**c. Plan for the Coming Year**

• Provide financial assistance under CSHS with family income up to 250% of FPL with no cost share.

• Identify additional training and resources to assist adolescents and their families in planning for their adult care.

• Maintain DOH representation on various advisory committees that assist families access services.

• Distribute materials developed by SDPC in collaboration with South Dakota Advocacy Services that address transition to adulthood for families of CYSHCN.

• Pursue collaboration/referral opportunities with SDPC and other state programs and agencies serving this population.

• Financially support SDPC transition activities for CYSHCN.

**Performance Measure 07:** *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2007** | **2008** | **2009** | **2010** | **2011** |
|---|---|---|---|---|---|
| Annual Performance Objective | 86 | 75 | 86 | 75 | 84.5 |
| Annual Indicator | 74.9 | 78.9 | 73.1 | 79.4 | 76.8 |
| Numerator | 11798 | 9802 | 9180 | 15148 | 14261 |
| Denominator | 15742 | 12430 | 12558 | 19068 | 18566 |
| Data Source | | SD Immunization Information System | SD Immunization Information System | SD Immunization Information System | SD Immunization Information System |
| Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2012** | **2013** | **2014** | **2015** | **2016** |
| Annual Performance Objective | 84.5 | 85 | 85 | 85 | 85 |

**Notes - 2011**
2011 South Dakota Immunization Information System data

**Notes - 2010**
2010 South Dakota Immunization Information System data. The numerator and denominator have dropped in 2010 because of data reporting inconsistencies and removal of duplication. Since the denominator has changed, the improvement seen in the 2010 data is a more accurate estimation of immunization coverage in South Dakota compared to previous reporting year.

**Notes - 2009**
2009 South Dakota Immunization Information System data

**a. Last Year's Accomplishments**

• Purchased Varicella and influenza vaccine.

• Served as a "universal-select" vaccine provider to distribute federally-funded vaccine free of charge.

• Offered Menactra to underinsured children age 11-18 years through OFCH sites designated as rural health clinics.

• Provided seasonal/H1N1 influenza vaccinations for children age 6 months through 18 years through school-based and community clinics.

• Encouraged South Dakota birthing hospitals to enroll in South Dakota Immunization Information System (SDIIS) to promote birth dose of hepatitis B.

• Obtained hepatitis B vaccine status via EVRSS.

• Offered schools, universities/colleges, and Head Starts access to SDIIS.

• Distributed immunization materials to hospitals, clinics, DOH field offices, day cares, schools, Head Starts, and other interested organizations.

• Accessed immunization status of infants and children served by TANF, Medicaid, Bright Start home visit program, and Dakota Smiles Mobile Dental Program.

• Developed/refined local agency plans to improve the assessment, administration, and referral for immunizations which focuses on the WIC/immunization linkage and any infant/child seeking services in OFCH offices.

• Provided technical assistance and resources to seven active immunization coalitions.

• Conducted annual audits on immunization records for all kindergarten and transfer students.

• Expanded communication with vaccine providers and offered training for new and existing vaccine providers.

• Completed data warehouse for SDIIS to allow ad hoc reporting.

**Table 4a, National Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Continue as "universal-select" vaccine provider and distribute federally-funded vaccine. | | | X | |
| 2. Promote birth dose of Hepatitis B vaccine. | | | X | |
| 3. Promote vaccination of infants through education materials distributed in Bright Start boxes. | | | X | |
| 4. Offering VFC vaccines to underinsured children through OFCHS sites designated as rural health clinics. | | | X | |
| 5. Creating mobile application for SDIIS to allow access from smart phone devices. | | | | X |
| 6. Obtain newborn Hepatitis B vaccination status of newborns through EVRSS. | | | | X |
| 7. Completing quarterly immunization coverage assessments at state level as well as local public/private provider level. | | | | X |

| | | | | |
|---|---|---|---|---|
| 8. Promote immunization data entry into SDIIS. | | | | X |
| 9. Finalize HL7 connection between SDIIS and IHS. | | | | X |
| 10. Work on connection between SDIIS and electronic health records. | | | | X |

**b. Current Activities**

• Purchasing Varicella vaccine (2nd dose for school entry) and influenza vaccine (6 months-18 years).

• Purchasing/distributing Tdap vaccine to public/private providers to immunize 11-14 year olds.

• Providing VFC vaccines to underinsured children through OFCHS sites designated as RHCs.

• Encouraging enrollment in SDIIS for South Dakota birthing hospitals to promote birth dose of Hepatitis B.

• Obtaining Hepatitis B vaccination status of newborns using EVRSS.

• Distributing immunization material.

• Assessing immunization status of infants and children served by TANF, Medicaid, Bright Start, and Mobile Dental Program.

• Developing/refining local agency plans to improve immunization assessment, administration, and referral

• Conducting annual audits on immunization records for all kindergarten/transfer students.

• Promoting immunization data entry into SDIIS and offering training for new/existing vaccine providers.

• Creating mobile application for SDIIS to allow access from smart phone devices.

• Finalizing HL7 connection between SDIIS and IHS; working on connection between SDIIS and electronic health records.

• Working on HL7 bi-directional exchange between SDIIS and electronic health records (EHRs).

• Conducting quarterly immunization coverage assessments utilizing SDIIS data.

• Developing WIC Management Information System (MIS) and linking SDIIS to that system.

**c. Plan for the Coming Year**

• Purchase Varicella vaccine for 2nd dose required for school entry and influenza vaccine for universal distribution for children age 6 months to 18 years.

• Purchase and distribute Tdap vaccine to public and private providers in support of special initiative to immunize 11-14 year olds.

• Provide VFC vaccines to underinsured children through OCHS sites designated as rural health clinics.

• Serve on local community immunization workgroups to assess immunization needs and facilitate development of plans to immunize children.

• Encourage Immunization Program enrollment for all South Dakota birthing hospitals to promote the birth dose of hepatitis B.

• Obtain hepatitis B vaccination status of newborns through EVRSS.

• Distribute immunization materials to hospitals, clinics, DOH field offices, day cares, schools, Head Starts, and other interested organizations.

• Assess immunization status of infants and children served by TANF, Medicaid, Bright Start, and Dakota Smiles Mobile Dental Program.

• Develop and refine local agency plans to improve assessment, administration, and referral for immunizations. The local plan focuses on the WIC/Immunization linkage and any infant/child seeking services through OCHS/PHA offices.

• Partner with DSS to include immunization information to the Bright Start Welcome Boxes.

• Provide technical assistance and resources to seven active local community immunization coalitions.

• Conduct annual audits of immunization records for all kindergarten and transfer students.

• Promote immunization data entry into SDIIS.

• Offer training for new and existing vaccine providers.

• Maintain Blast Fax and Listserv to communicate with vaccine providers.

• Finalize a mobile application for SDIIS to allow access from smart phone devices.

• Finalize HL7 connection between SDIIS and the IHS system.

• Continue work on HL7 connection between SDIIS and electronic health records; anticipate having connection to one major health system in state by end of year with potential of up to 90 clinics exchanging data between EHRs and SDIIS.

**Performance Measure 08:** *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2007** | **2008** | **2009** | **2010** | **2011** |
|---|---|---|---|---|---|
| Annual Performance Objective | 18 | 18 | 19 | 18.5 | 15.7 |
| Annual Indicator | 19.8 | 20.8 | 18.5 | 15.8 | 15.2 |
| Numerator | 334 | 345 | 303 | 259 | 245 |
| Denominator | 16828 | 16591 | 16406 | 16342 | 16094 |
| Data Source | | Birth Certificate | Birth Certificate | Birth Certificate | Birth Certificate |
| Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2012** | **2013** | **2014** | **2015** | **2016** |
| Annual Performance Objective | 15 | 15 | 15 | 15 | 15 |

**Notes - 2011**
2011 South Dakota birth certificate data. Rate based on 2011 South Dakota population estimate.

**Notes - 2010**
2010 South Dakota birth certificate data. Rate based on 2010 South Dakota population estimate. The 2006-2010 five-year trend of the birth rate (per 1,000) for teenagers aged 15 through 17 years shows a downward trend. The data for this measure were collected using the South Dakota birth certificate data. The data shows a downward trend over the years. While the rates tend to fluctuate between the years, there are no significant differences between the years.

**Notes - 2009**
2009 South Dakota birth certificate data. Rate based on 2009 South Dakota population estimate.

**a. Last Year's Accomplishments**
• Provided family planning services to 2,446 adolescents age 19 and under during CY11; approximately 39.7% of adolescents seen were 17 years of age or younger.

• Provided community/school education services related to reproductive health to 5,040 adolescents in CY11.

**Table 4a, National Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Negotiate new contracts for the provision of abstinence education. | | | | X |
| 2. Provide reproductive health services to adolescents. | | | X | |
| 3. Provide community/school education programs related to reproductive health upon request. | | | X | |
| 4. Collaborate with community-based organizations to identify new strategies to reduce the rate of births for adolescents. | | | | X |
| 5. Provide Personal Responsibility Education Program (PREP) activities. | | | X | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**
• Providing family planning services to adolescents including counseling, education, medical exams, STD screening, and contraceptive supplies.

• Providing community/school education services related to reproductive health upon request to adolescents.

**c. Plan for the Coming Year**
• Provide family planning services to adolescents including counseling, education, medical exams, STD screening, and contraceptive supplies.

• Provide community/school education services related to reproductive health upon request to adolescents.

**Performance Measure 09:** *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2007** | **2008** | **2009** | **2010** | **2011** |
|---|---|---|---|---|---|
| Annual Performance Objective | 55 | 61.5 | 61.5 | 61.5 | 59 |
| Annual Indicator | 61.1 | 61.1 | 61.1 | 54.8 | 54.8 |
| Numerator | 392 | 392 | 392 | 5568 | 5568 |
| Denominator | 642 | 642 | 642 | 10160 | 10160 |
| Data Source | | SD Oral Health Survey | SD Oral Health Survey | SD Oral Health Survey | SD Oral Health Survey |
| Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2012** | **2013** | **2014** | **2015** | **2016** |
| Annual Performance Objective | 59.5 | 60 | 60.5 | 61 | 61 |

**Notes - 2011**
2010 South Dakota oral health survey weighted data.

**Notes - 2010**
2010 South Dakota oral health survey weighted data. The 2006-2010 five-year trend of the percentages of third grade children who have received protective sealants on at least one permanent molar tooth shows an downward trend. The data were collected using two random surveys conducted from, March through May 2006, and March through May 2010. The data provided shows no significant differences between the years.

**Notes - 2009**
2006 South Dakota oral health survey data

**a. Last Year's Accomplishments**
• Provided oral health educational materials and resources through dental clinics, DOH offices, Head Start/Early Head Start, FQHCs, health fairs, professional meetings/conferences, etc.

• Partnered with Delta Dental to support the mobile Dakota Smile Programs efforts to provide dental services in dental HPSAs including Native American communities.

• Collaborated with the Community Health Center of the Black Hills to implement dental programs in the school-based health clinic.

• Provided support for the Dental Externship Program to encourage students to further their dental career in South Dakota.

• Provided support for the Health Occupations for Today and Tomorrow program (HOTT) to introduce high school students to health professional careers including dentistry.

• Partnered with the USD Dental Hygiene Program to support delivery of preventive intervention services, including dental sealants.

• Provided support for the Sisseton-Wahpeton Oyate Tribes "Caries Free by 2-0-1-3" project to prevent dental disease in young children.

**Table 4a, National Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Provide oral health resources statewide. | | | | X |
| 2. Conduct Basic Screening Survey of Head Start/Early Head Start children. | | | X | |
| 3. Improve access to dental care through support of the Dakota Smiles Program. | X | | | |
| 4. Provide support for the ORH Dental Externship program. | | | X | |
| 5. Collaborate with USD Dental Hygiene program to implement preventive intervention projects including dental sealants. | | | | X |
| 6. Collaborate with Delta Dental to provide oral health resources statewide and dental services in Native American communities. | | | | X |
| 7. Collaborate with the Community Health Center of the Black Hills to implement a dental sealant program in the school-based health clinic. | | | | X |
| 8. Support Oral Health Coalition's efforts to promote the collaborative supervision agreement to enhance the dental workforce. | | | | X |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

• Conducting Basic Screening Survey (BSS) of Head Start/Early Head Start children.

• Improve access to dental care through support of the Dakota Smiles program that is a mobile dental program serving dental HPSAs.

• Provide support for ORH Dental Externship program to encourage dental students to pursue a dental career in South Dakota.

• Collaborate with USD Dental Hygiene program to implement preventive intervention projects including dental sealants.

• Collaborate with Delta Dental to provide oral health resources statewide and dental services in Native American communities.

• Collaborate with the Community Health Center of the Black Hills to implement a dental sealant program in the school-based health clinic.

• Support the Oral Health Coalition's efforts to promote the collaborative supervision agreement to enhance the dental workforce in South Dakota.

**c. Plan for the Coming Year**

• Facilitate oral health education/training opportunities and updates for DOH, CHCs, Head Starts, day cares, and other health care providers.

• Work with SDDA and Delta Dental to distribute information to dental/medical professionals about oral health-related performance measures, and collection of data to measure progress towards objectives.

• Continue discussions with Medicaid, Delta Dental, SDDA, and ORH regarding options for improving access to oral health care for children in South Dakota.

• Partner with ORH to support the Dental Tuition Reimbursement Program.

• Provide educational materials and resources through dental clinics, DOH offices, Head Start/Early Head Start, FQHCs, IHS, Urban Indian Health, health fairs, day care providers, professional meetings/conferences, etc.

• Participate on Advisory Board for the Dakota Smiles Mobile Dental Program and provide financial support for the mobile program; provide oral health educational materials for the Dakota Smiles Program patients and families.

• Contract with Delta Dental to support the mobile dental Dakota Smile Programs efforts to improve access in dental HPSA including Native American communities.

• Provide oral health materials and resources to DOH regional managers and CHNs for distribution to the families they serve.

• Finalize the BSS of Head Start/Early Head Start children; generate and disseminate report of BSS.

• Contract with USD to implement sealant programs and preventive interventions for underserved populations.

• Contract with Delta Dental to provide oral health training and resources for non-dental health professionals, including OB/GYNs.

• Partner with Community Health Clinics to enhance school-based health clinics oral health components, by implementing a dental sealant program.

• Distribute resources that have been translated into Spanish.

**Performance Measure 10:** *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2007 | 2008 | 2009 | 2010 | 2011 |
|---|---|---|---|---|---|
| Annual Performance Objective | 9.5 | 5.1 | 3 | 4 | 4 |
| Annual Indicator | 5.1 | 3.1 | 4.3 | 4.2 | 4.2 |
| Numerator | 8 | 5 | 7 | 7 | 7 |
| Denominator | 156390 | 161819 | 163841 | 166278 | 168300 |
| Data Source | | Death Certificate | Death Certificate | Death Certificate | Death Certificate |
| Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2012** | **2013** | **2014** | **2015** | **2016** |
| Annual Performance Objective | 4 | 4 | 4 | 4 | 4 |

**Notes - 2011**
2009-2011 South Dakota death certificate data. Numerator and denominator are 3-year averages. Rates are based on 2009-2011 South Dakota population estimates.

**Notes - 2010**
2008-2010 South Dakota death certificate data. Numerator and denominator are 3-year averages. Rates are based on 2008-2010 South Dakota population estimates. The 2006-2010 five-year trend of the rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children shows a downward trend. The data for this measure were collected using the South Dakota death certificate data. Due to small numbers, 3-year averages were used. While the rates tend downward none of the rates are significantly different from the other.

**Notes - 2009**
2007-2009 South Dakota death certificate data. Numerator and denominator are 3-year averages. Rate is based on 2007-2009 South Dakota population estimates.

**a. Last Year's Accomplishments**
• Promoted community awareness campaigns designed to increase seat belt use (i.e., May Mobilization Seat Belt Campaign, Buckle Up Bulldogs, Kids Safe Saturday, Miss Click-It Safety Clown presentations at daycares, and Boys and Girls Club seatbelt coloring contest).

• Attended the 7th Annual South Dakota Safety Conference to network with other agencies and identify opportunities to promote roadway safety.

• Promoted "Parents Matter" and other prevention campaigns which promote anti-drinking and driving with youth across the state.

• Collaborated with DSS on the Project 8 Program which provides a coordinated statewide system of child safety seat education and inspection in South Dakota; 4,312 car seats were distributed to eligible families along with instructions on proper installation techniques; 2,506 additional car seats were inspected (85% were installed incorrectly); 116 public education events were held reaching 4,933 individuals.

• Supported the Safe Routes to School activities to improve safety for children walking or biking to school.

• Participated on a technical panel as part of the Driver Education Research Project to identify/recommend the most effective driver education programs for young drivers.

**Table 4a, National Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Collaborate with local advocates, law enforcement, and emergency responders statewide to enhance public awareness and promote the use of seatbelts. | | | X | |
| 2. Participate in Transportation Safety Conference to network with statewide agencies to improve roadway safety. | | | | X |
| 3. Collaborate with prevention agencies to address underage drinking and impaired driving. | | | | X |
| 4. Promote the Project 8 Program which provides a coordinated statewide system of child safety seat education and inspection. | | | X | |
| 5. Promote the Safe Routes to Schools Program which provides funding to school districts to improve safety concerns for children walking and biking to school. | | | X | |
| 6. Support South Dakota's Teen Driving Task Force to examine and review data, laws, practices, and policies related to teen driving education, licensing, and safety. | | | | X |
| 7. Collaborating to provide risk reduction training to youth. | | | X | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

• Promoting numerous statewide campaigns and local events promoting seatbelt safety (i.e., May Mobilization Seat Belt Campaign, Sioux Empire Fair Safety Tent, Buckle Up Bulldogs, Kids Safe Saturday, Miss Click-It Safety Clown daycare presentations, and Oglala Sioux Tribe Sacred Cargo campaign which promotes seatbelt/car seat use on the Pine Ridge Reservation).

• Participating on Transportation Safety Conference to network and promote roadway safety issues.

• Promoting underage alcohol and impaired driving prevention activities (i.e., Parents Matter and Oglala Sioux Tribe Don't Shatter the Dream Campaign that addresses speeding and impaired/distracted driving on the Pine Ridge Reservation.

• Supporting Project 8 child safety seat distribution, education and inspection.

• Promoting Safe Route to School activities to improve safety for children walking or biking to school.

• Supporting the Teen Driving Task Force which was formed to provide recommendations for improving teen driver safety.

• Collaborating with several agencies via Abstinence Education funding to provide risk reduction education including drug and alcohol use and appropriate decision making; 231 youth have

received education (41% are Native American).

**c. Plan for the Coming Year**

• Support statewide high visibility enforcement campaigns and activities promoting seat belt use.

• Participate in Traffic Safety Conference and the Tribal Traffic Safety Conference.

• Support prevention activities promoting anti-drinking and driving in school systems and communities in the state.

• Collaborate with agencies to continue distribution, education, and inspection of child safety seats as Project 8 funding ends in September 2012.

• Support Safe Routes to Schools program which provides funding to schools to increase safety of children walking or biking to school.

• Support Driver Education Research Project to identify/recommend the most effective driver education programs for young drivers.

• Collaborate with agencies providing risk reduction/decision making education to youth in the state via Abstinence Education funding.

**Performance Measure 11:** *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2007** | **2008** | **2009** | **2010** | **2011** |
|---|---|---|---|---|---|
| Annual Performance Objective | 43 | 44 | 44 | 47.5 | 48.5 |
| Annual Indicator | 40.5 | 41.8 | 47.5 | 48.5 | 44.5 |
| Numerator | | | | | |
| Denominator | | | | | |
| Data Source | | National Immunization Survey | National Immunization Survey | National Immunization Survey | National Immunization Survey |
| Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data | | | | Final | Final |

| Provisional or Final? | | | | | |
|---|---|---|---|---|---|
| | **2012** | **2013** | **2014** | **2015** | **2016** |
| Annual Performance Objective | 48.5 | 49 | 49 | 49 | 49 |

**Notes - 2011**
2011 National Immunization Survey (NIS) data. Numerator and denominator are not available.

**Notes - 2010**
2010 National Immunization Survey (NIS) data. Numerator and denominator are not available. The 2006-2010 four-year trend of the percentages of mothers who breastfeed their infants at 6 months of age shows upward trend. These data are taken from the National Immunization Survey website for breastfeeding data. The data provided shows that none of the years are significantly different from the other.

**Notes - 2009**
2009 National Immunization Survey (NIS) data. Numerator and denominator are not available.

**a. Last Year's Accomplishments**
• Partnered with HealthySD and worksite wellness to promote breastfeeding and education on worksite lactation support.

• Developed a statewide breastfeeding media campaign to promote breastfeeding which included radio spots, social media site, and printed materials.

• Provided updated breastfeeding information on the DOH and HealthySD websites.

• Developed and purchased materials for World Breastfeeding Week.

• Continually worked with communities to improve overall support and environment for breastfeeding.

• Developed state plan addressing breastfeeding rates and target rates statewide.

• Developed nutritional goals to target pregnant women for early prenatal care as well as individual local agency breastfeeding target rates.

• Developed breastfeeding.org website.

• Collected and reviewed breastfeeding rates for the state, individual local agencies, and individual hospitals statewide.

**Table 4a, National Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Partner with Healthy SD and Worksite Wellness to promote breastfeeding and educate on worksite lactation support. | | | | X |
| 2. Develop breastfeeding media campaign to promote breastfeeding across the state. | | | X | |
| 3. Develop breastfeeding resources for mothers, employers, and health care providers. | | | | X |
| 4. Update breastfeeding information on healthysd.gov and DOH websites. | | | | X |

| | | | | |
|---|---|---|---|---|
| 5. Improve and design additional reports to track breastfeeding rates. | | | X | |
| 6. Develop, purchase, and distribute materials for World Breastfeeding Week. | | | | X |
| 7. Address breastfeeding environment and support in communities. | | | | X |
| 8. Develop and implement a statewide plan to improve breastfeeding rates. | | | | X |
| 9. Develop breastfeeding website | | | | X |
| 10. Collect breastfeeding rates for state and individual hospitals and review maternity care practices. | | | | X |

**b. Current Activities**

• Partnering with HealthySD and worksite wellness to promote breastfeeding

• Developing breastfeeding materials for businesses and healthcare providers.

• Updating breastfeeding resources to be distributed through WIC.

• Revising breastfeeding policies to strengthen promotion and education for all women.

• Upgrading and increasing the number of breast pumps available to WIC participants.

• Providing monthly newsletters containing breastfeeding messages to WIC participants.

• Conducting participant survey to address barriers to breastfeeding.

• Developing state plan for improving breastfeeding rates.

• Issuing more food to mothers choosing to breastfeed their infant according to WIC federal regulations.

• Providing annual breastfeeding training to all staff.

• Providing speaker to selected hospitals regarding building momentum to meet Baby Friendly Hospital 10 step program.

• Working with Bright Start Nurse Home Visiting program to assure appropriate referrals take place.

**c. Plan for the Coming Year**

• Provide breastfeeding education to health care providers based on current breastfeeding rates and maternity care practices.

• Activate breastfeeding coalition to provide a networking system for breastfeeding education and promotion.

• Conduct breastfeeding awareness activities and promote World Breastfeeding Week.

• Promote breastfeeding to reduce infant mortality rates.

**Performance Measure 12:** *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2007** | **2008** | **2009** | **2010** | **2011** |
|---|---|---|---|---|---|
| Annual Performance Objective | 93 | 97.5 | 98 | 98 | 98 |
| Annual Indicator | 97.3 | 98.0 | 97.7 | 97.5 | 97.1 |
| Numerator | 12475 | 12374 | 12200 | 12075 | 12105 |
| Denominator | 12815 | 12631 | 12481 | 12382 | 12470 |
| Data Source | | Newborn Hearing Screening Program | Newborn Hearing Screening Program | Newborn Hearing Screening Program | Newborn Hearing Screening Program |
| Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2012** | **2013** | **2014** | **2015** | **2016** |
| Annual Performance Objective | 98 | 98 | 98 | 98 | 98 |

**Notes - 2011**
2011 South Dakota Newborn Hearing Screening Program data.

**Notes - 2010**
2010 South Dakota Newborn Hearing Screening Program data. The 2006-2010 five-year trend of the percentage of mothers who breastfeed their infants at hospital discharge shows a flat trend. These data are taken from the South Dakota Newborn Hearing Screening Program data. The data provided shows that 2006 and 2010 data are significantly different from the other years, 2009 is not significantly different from 2007 and 2008, but 2007 is significantly different from the 2008 data.

**Notes - 2009**
2009 South Dakota Newborn Hearing Screening Program data.

**a. Last Year's Accomplishments**
• Collaborated with hospitals to ensure all babies born in South Dakota receive appropriate hearing screening, evaluation, and intervention.

• Provided technical assistance to audiologists on entering screening, rescreening, and diagnostic audiological results into EVRSS.

• Cooperated with Sanford Children's Genetics Hearing Loss Clinic.

• Met with Early Head Start program to discuss strategies for reporting hearing screening data, data linkages, and future collaborations.

• Distributed Newborn Hearing Screening materials as requested

• Provided EVRSS reports to birthing hospitals to facilitate reporting follow-up of missed initial hearing screening and rescreen hearing results.

• Conducted an outside evaluation of the Newborn Hearing Screening program including data and surveillance to identify strengths and weaknesses of the hearing screening process.

• Maintained list of pediatric diagnostic audiology facilities in South Dakota.

• Updated the Newborn Hearing Screening website.

• Conducted site visits to the state's largest birthing centers to discuss the hearing screening process and reporting of hearing screening data to the program.

• Participated on the Heartland Regional Collaborative's Early Hearing Detection and Intervention (EHDI) workgroup.

**Table 4a, National Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Maintain/improve newborn hearing screening data collection system | | | | X |
| 2. Maintain/update newborn hearing screening website. | | | | X |
| 3. Ensure infants receive timely hearing screening, evaluation, and intervention. | | | X | |
| 4. Distribute educational materials regarding infant hearing loss. | | | X | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

• Collaborating with facilities to ensure all babies born in South Dakota receive appropriate hearing screening, evaluation and intervention.

• Updating and distributing Newborn Hearing Screening materials as requested.

• Participating on the Heartland Regional Collaborative's EHDI workgroup.

• Attending annual EHDI meeting in St. Louis, MO.

• Updating audiologist EHDI EVRSS worksheet with parental consent for reporting diagnostic and intervention data.

• Exploring capabilities of obtaining intervention data with Early Head Start and Birth to 3 programs.

• Providing training and technical assistance to EVRSS users for EHDI data reporting.

• Enhancing EVRSS reports to capture infants transferred to another facility following birth.

• Utilizing EVRSS reports to facilitate reporting of hearing screening results of missed or repeat hearing screenings.

• Cooperated with the Sanford Children's Hearing Loss Center.

**c. Plan for the Coming Year**

• Collaborate with facilities to ensure all babies born in South Dakota receive appropriate hearing screening, evaluation, and intervention.

• Distribute Newborn Hearing Screening materials as requested.

• Develop a parental consent form to facilitate collection of intervention data.

• Enhance EVRSS to collect intervention data.

• Offer technical assistance and training to pediatric audiologists regarding reporting diagnostic data.

• Partner with Birth to 3 and Early Head Start programs.

## Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2007** | **2008** | **2009** | **2010** | **2011** |
|---|---|---|---|---|---|
| Annual Performance Objective | 3.2 | 2.7 | 2.7 | 2.1 | 2.1 |
| Annual Indicator | 2.8 | 2.9 | 2.1 | 2.3 | 1.3 |
| Numerator | 5451 | 5751 | 4192 | 4404 | 2594 |
| Denominator | 194681 | 198309 | 199616 | 191880 | 193976 |
| Data Source | | BRFSS | BRFSS | BRFSS | BRFSS |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2012** | **2013** | **2014** | **2015** | **2016** |
| Annual Performance Objective | 1 | 1 | 1 | 1 | 1 |

**Notes - 2011**
2011 BRFSS weighted data. Rate based on 2011 South Dakota population estimate.

**Notes - 2010**
2010 BRFSS weighted data. Rate based on 2010 South Dakota population estimate. The 2006-2010 five-year trend of the percent of children without health insurance shows a declining trend.

The data for this measure were collected with the BRFSS. The data provided appears to fluctuating over the years even though none of the years are significantly different from the others.

**Notes - 2009**
2009 South Dakota BRFSS survey weighted data. Rate based on 2009 South Dakota population estimate.

**a. Last Year's Accomplishments**
• Collaborated with DSS to assure information regarding SCHIP and the expanded non-Medicaid SCHIP program was distributed to DOH staff and communities. Communication occurs at numerous levels including upper management.

• Provided SCHIP applications to OFCH offices and assisted in completion of forms as needed.

• Provided links to DSS Medicaid website from the DOH website.

• Required all clients requesting financial assistance with CSHS to first apply for Title XIX.

• Provided information regarding the South Dakota Risk Pool to families.

**Table 4a, National Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Assure information regarding SCHIP is distributed to DOH staff and communities. | | | | X |
| 2. Provide SCHIP applications in DOH field offices and assist with completion of forms as needed. | | | X | |
| 3. Provide links to DSS Medicaid website from DOH website. | | | | X |
| 4. Assure information regarding the South Dakota Risk Pool is available. | | | | X |
| 5. Provide transition planning information. | | X | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**
• Collaborating with DSS to assure information regarding SCHIP and the expanded non-Medicaid SCHIP program is distributed to DOH staff and communities.

• Assuring families accessing DOH programs are provided information on available programs (i.e., SCHIP, Medicaid and Risk Pool).

• Identifying avenues to share information with families of adolescents that will be aging out of Medicaid at age 19 since they have many times not considered how they will cover their medical costs once they are no longer eligible. While CSHS can help with the cost of covered medical conditions, it can't cover acute illnesses and treatment for non-covered medical conditions.

• Assisting families access IHS-contracted services/assistance as appropriate.

• Attended an employment and benefits workshop in order to present accurate information on

Social Security, Medicaid, and Medicare benefits.

• Linking CSHS families to participating providers who agreed to CSHS reimbursement rates.

• Providing information to families on the Affordable Care Act and changes in insurance coverage for pre-existing health conditions.

**c. Plan for the Coming Year**

• Provide financial assistance under CSHS to families up to 250% of FPL with no cost share.

• Require all clients requesting financial assistance with CSHS to first apply for Title XIX.

• Provide information on the South Dakota Risk Pool to individuals who have lost their insurance coverage through no fault of their own and are unable to access different coverage.

• Identify avenues to share information on insurance planning for adolescents who will be aging out of Medicaid at age 19.

• Link CSHS families to participating providers who have agreed to CSHS reimbursement rates.

**Performance Measure 14:** *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2007** | **2008** | **2009** | **2010** | **2011** |
|---|---|---|---|---|---|
| Annual Performance Objective | 31 | 34 | 35 | 35 | 34 |
| Annual Indicator | 34.6 | 35.9 | 36.3 | 35.4 | 33.2 |
| Numerator | 2993 | 3276 | 3523 | 3578 | 3437 |
| Denominator | 8651 | 9125 | 9705 | 10106 | 10351 |
| Data Source | | PedNSS | PedNSS | PedNSS | PedNSS |
| Check this box if you cannot report the numerator because<br>1.There are fewer than 5 events over the last year, and<br>2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2012** | **2013** | **2014** | **2015** | **2016** |
| Annual Performance Objective | 33 | 32 | 32 | 32 | 32 |

**Notes - 2011**
2011 South Dakota Pediatric Nutrition Surveillance System (PedNSS) data.

**Notes - 2010**
2010 South Dakota Pediatric Nutrition Surveillance System (PedNSS) data. The 2006-2010 five-year trend of the percentages of children, ages 2 to 5 years, receiving WIC services with a BMI at or above the 85th percentile shows a gradual upward trend. The data for this measure were collected with the SD PedNSS. The data provided shows that 2006 data are significantly different from the other years data.

**Notes - 2009**
2009 South Dakota Pediatric Nutrition Surveillance System (PedNSS) data.

**a. Last Year's Accomplishments**
• Collaborated with partners to implement strategies in the State Plan to Prevent Obesity and Other Chronic Diseases especially those objectives and strategies focused on parents and caregivers.

• Collaborated to use evaluation of Fit from the Start Initiative to develop the fit-Care curriculum for registered and licensed childcare facilities.

• Co-sponsored special supplement to SDSMA medical journal on obesity prevention and treatment.

• Utilized HealthySD.gov and DOH websites to provide updated consumer and provider resources for overweight children and adolescents.

• Co-sponsored South Dakota State University (SDSU) Nutrition Seminar.

• Collaborated with GFP to offer backpacks to childcare providers that had activities to do outdoors to increase physical activity -- 181 backpacks awarded in 2010 to childcare homes and centers in 68 communities, 4,779 kids engaged as estimated by providers. In 2010, an additional 287 backpacks awarded to 130 communities reaching over 7,700 kids. The backpacks are designed to enhance time spent in nature in any setting (i.e., field trips, outings to local parks, walks around neighborhood, free play in backyard).

• Provided "Fruits and Veggies - More Matters" materials for parents to increase fruit and vegetable intake.

• Promoted National Turn of the TV Week in collaboration with program partners and HealthySD.

• Implemented WIC food package which includes fresh fruits and vegetables, whole grains, and lower fat milk.

• Provided WIC Wellness Nutrition Fun Facts Newsletters to all WIC participants that included recipes and information on breastfeeding, nutrition, and physical education.

• Obtained a Governor's Proclamation to celebrate World Breastfeeding Week with the theme "Breastfeeding is Important -- Let's Talk About It".

• Celebrated National Nutrition Month in WIC clinics with posters and educational materials on ChooseMyPlate. Brought Dr. Marianne Neifert to Rapid City Regional Hospital for a training on hospital practices to increase rates and duration of breastfeeding.

• Trained WIC nutrition staff on providing participant-centered services to better meet the individual nutrition needs of WIC clients.

**Table 4a, National Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Partner to provide nutrition and physical activity expertise in DOH. | | | | X |
| 2. Collaborate with partners to implement strategies in the State Plan to Prevent Obesity and Other Chronic Disease and to | | | | X |

| | | | | |
|---|---|---|---|---|
| develop a new 5 year plan. | | | | |
| 3. Implement the interim WIC food package to include fresh fruits and vegetables, whole grains, and lower fat milk; distribute "Get Healthy Now" kit to all 2-5 year old participants. | | | X | |
| 4. Complete fitCare curriculum, train Early Childhood Enrichment specialists to train child care providers, and start implementing in childcare facilities to increase access to vegetables, improve opportunities for physical activity, and decrease tv vie | | | | X |
| 5. Provide educational information and materials to DOH staff and others for use with parents and childcare providers on how to increase physical activity for all ages of children including strategies to decrease TV viewing. | | | X | |
| 6. Collaborate with partners to educate parents and childcare providers on the importance of good nutrition and physical activity for children. | | | X | |
| 7. Implement new WIC MIS which will offer improved opportunities for data collection on nutrition and physical activity related needs and risks of WIC clients statewide and regionally. | | | | X |
| 8. Utilize the HealthySD.gov and DOH websites to provide updated consumer and provider resources for overweight children and adolescents. | | | X | |
| 9. Provide grants for registered dietitians to obtain CDR certificate of training in pediatric weight management. | | | X | |
| 10. Implement interim WIC food package, including education materials for WIC participants on how to best use their fruit and vegetable vouchers. | | | X | |

**b. Current Activities**

• Providing media messages regarding healthy strategies to prevent obesity, particularly increased fruit and vegetable intake.

• Co-sponsoring SDSU Nutrition seminar including speaker on child obesity.

• Providing WIC Wellness Nutrition Fun Facts newsletters to WIC participants that includes recipes and information on breastfeeding, nutrition, and physical education.

• Utilizing statewide DOH media campaign to promote breastfeeding.

• Training all WIC staff on providing participant-centered services to better meet the individualized nutrition and physical activity needs of WIC clients.

**c. Plan for the Coming Year**

• Implement selected interventions to reverse low fruit and vegetable consumption by South Dakotans.

• Provide educational information and materials to DOH staff and interested parties for use with parents and others who serve preschool children on how to increase physical activity and healthy eating, especially fruits and vegetables.

• Continue implementation of 2010 State Plan to Prevent Obesity and Other Chronic Diseases.

• Work with partners to educate parents on the importance of good nutrition and physical activity for their children.

• Utilize DOH and HealthySD.gov websites to provided updated consumer and provider resources for overweight and obese children.

• Collaborate with GFP to encourage physical activity in state and local parks.

• Implement fitCare initiative in childcare facilities.

• Sponsor training by Dr. Marianne Neifert at Avera St. Lukes in Aberdeen and Avera McKennan and Sanford in Sioux Falls to train health professional staff and community partners on hospital practices to improve rates and duration of breastfeeding.

• Implement providing participant-centered services in all WIC clinics to better meet the individualized nutrition and physical activity needs of WIC clients.

• Use WIC MIS to provide more complete health and nutrition data to better identify the nutrition and physical activity needs of WIC families statewide and regionally.

• Increase marketing messages related to National Nutrition Month and World Breastfeeding Week within WIC clinics.

**Performance Measure 15:** *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2007** | **2008** | **2009** | **2010** | **2011** |
|---|---|---|---|---|---|
| Annual Performance Objective | 14 | 14 | 13 | 12.9 | 11.8 |
| Annual Indicator | 14.2 | 13.0 | 12.9 | 11.9 | 11.5 |
| Numerator | 1707 | 1545 | 1520 | 1380 | 1336 |
| Denominator | 12061 | 11859 | 11775 | 11606 | 11661 |
| Data Source | | Birth Certificate | Birth Certificate | Birth Certificate | Birth Certificate |
| Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2012** | **2013** | **2014** | **2015** | **2016** |
| Annual Performance Objective | 11 | 11 | 11 | 11 | 11 |

**Notes - 2011**
2011 South Dakota birth certificate data.

**Notes - 2010**
2010 South Dakota birth certificate data. The 2006-2010 three-year trend of the percentage of women who smoke in the last three months of pregnancy shows a slight downward trend. The data for this measure were collected using the South Dakota birth certificate data. The data

provided shows that only 2007 is significantly different from 2009, all other years are not significantly different from the other.

**Notes - 2009**
2009 South Dakota birth certificate data

**a. Last Year's Accomplishments**
• Risk assessed pregnant clients and provided tobacco cessation/referral services to clients.

• Promoted South Dakota QuitLine to assist pregnant women quit using tobacco.

• Provided training to professionals about the risks associated with smoking during pregnancy.

• Provided tobacco prevention materials in Bright Start Welcome Boxes to reinforce the message of not smoking during future pregnancies and preventing secondhand smoke exposure for infants and young children.

**Table 4a, National Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Risk assess all pregnant women seeking services within OFCH offices for smoking status three months prior to pregnancy as well as current smoking status. | | | X | |
| 2. Provide education, informational materials, and referrals to encourage and assist with smoking cessation. | | X | | |
| 3. Collaborate with a variety of organizations to educate professionals about the risks associated with smoking during pregnancy. | | | | X |
| 4. Collaborate with DSS to include tobacco prevention materials and incentives in the Bright Start Welcome Boxes. | | | X | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**
• Risk assessing pregnant clients and providing tobacco cessation/referral services to clients.

• Promoting South Dakota QuitLine to assist pregnant women quit using tobacco.

• Providing training to professionals about the risks associated with smoking during pregnancy.

• Providing tobacco prevention materials in Bright Start Welcome Boxes to reinforce the message of not smoking during future pregnancies and preventing secondhand smoke exposure for infants and young children.

• Collaborating with DSS to develop and distribute a pregnancy resource folder for pregnant women which includes tobacco prevention messages.

• Providing tobacco prevention education materials and technical assistance to health care providers as requested.

• Continuing collaboration with March of Dimes, Perinatal Association, American Cancer Society, and CHAD to educate professionals about the risks associated with smoking during pregnancy.

• Conducting media campaign "I Will Keep You Safe" targeting pregnant women.

• Created public education campaign "What Would You Do to Save Your Child's Life?" for TV, radio, and print media targeted toward low income and Native American mothers.

**c. Plan for the Coming Year**

• Promote South Dakota QuitLine for pregnant women.

• Contact health care providers to provide tobacco prevention education materials, commercial tobacco cessation, and technical assistance.

• As a result of the Governor's Task Force on Infant Mortality, collaborate with DSS to promote safe sleep habits and eliminate infant exposure to secondhand smoke.

• Collaborate with March of Dimes, Perinatal Association, American Cancer Society, and CHAD to educate professionals about the risks associated with smoking during pregnancy.

• Risk assess pregnant clients and provide tobacco cessation/referral services to clients.

• Continue meeting with Healthy Start staff to build relationships, obtain data, and provide tobacco prevention materials/technical support.

• Conduct statewide public education/media campaign targeting pregnant women.

**Performance Measure 16:** *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2007** | **2008** | **2009** | **2010** | **2011** |
|---|---|---|---|---|---|
| Annual Performance Objective | 17 | 22 | 22 | 24.2 | 28 |
| Annual Indicator | 22.2 | 24.1 | 25.9 | 29.4 | 24.1 |
| Numerator | 13 | 14 | 15 | 17 | 14 |
| Denominator | 58689 | 58105 | 57894 | 57883 | 58038 |
| Data Source | | Death Certificate | Death Certificate | Death Certificate | Death Certificate |
| Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2012** | **2013** | **2014** | **2015** | **2016** |

| | | | | | |
|---|---|---|---|---|---|
| Annual Performance Objective | 24 | 24 | 24 | 24 | 24 |

**Notes - 2011**
2009-2011 South Dakota death certificate data. Numerator and denominator are 3-year averages. Rate is based on 2009-2011 South Dakota population estimates. The

**Notes - 2010**
2008-2010 South Dakota death certificate data. Numerator and denominator are 3-year averages. Rate is based on 2008-2010 South Dakota population estimates. The 2006-2010 five-year trend of the rate (per 100,000) of suicide deaths among youths aged 15-19 shows a slight upward trend. The data for this measure were collected using the South Dakota death certificate data. Due to small numbers, 3-year averages were used. The data provided shows that while the rates tend to fluctuate between the years, there are no significant differences between the years.

**Notes - 2009**
2007-2009 South Dakota death certificate data. Numerator and denominator are 3-year averages. Rate is based on 2007-2009 South Dakota population estimates.

**a. Last Year's Accomplishments**
• Partnered with DSS to fund the Front Porch Coalition and HELP! Line Center to: (1) provide consultation and support for suicide awareness partnership activities including distribution of promotional materials for the National Suicide Prevention Lifeline phone number as well as provided additional ASIST and QPR trainings for caregivers in suicide intervention; (2) answer crisis line phone calls from across the state at the HELP! Line Centers through the National Suicide Prevention Lifeline; and (3) analyze Crisis Line call data.

• Participated in the South Dakota Strategy for Suicide Prevention planning meetings.

• Promoted training of survivor group facilitators and provided survivor packets.

• Helped fun and support the statewide Suicide Prevention website.

• Support DSS (Garrett Lee Smith grant recipient) with Community Partnership for Suicide Prevention (CPSP) efforts in 10 grant recipient communities to implement local suicide prevention strategies.

• Via the Suicide Prevention website, promoted state and national Native American suicide resources including the Tribal Youth Suicide Prevention and Early Intervention Project at the Wiconi Waken (Sacredness of Life) Health and Healing Center on the Rosebud Sioux Reservation.

**Table 4a, National Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Participate in task force planning meetings sponsored by DSS. | | | | X |
| 2. Support training of HELP! | | | | X |
| 3. Support update of database of mental health providers/emergency services providers for referral purposes. | | | | X |
| 4. Provide training and materials for facilitators of suicide survivor support groups and funeral directors. | | X | | |
| 5. Provide consultation and support of Garrett Lee Smith grant activities and sustainability efforts. | | | | X |
| 6. Refine and update suicide prevention website. | | | | X |

| | | | | |
|---|---|---|---|---|
| 7. Improve collection of suicide attempt data. | | | | X |
| 8. Support Crisis Line texting capabilities including development, software/equipment, training, and promotion of texting. | | | | X |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

• Partnering with DSS to fund the HELP! Line Center to: (1) maintain, operate, and analyze data for the Crisis Line and provide follow-up calls to high-risk suicidal callers; (2) provide training for survivor group facilitators and funeral home directors, and provide packets to survivors of suicide; (3) collect suicide attempt data; (4) develop Crisis Line texting capability and pilot Crisis Line texting in three South Dakota high schools; and (5) update mental health and emergency service resource database.

• Supporting DSS (Garrett Lee Smith recipient) activities in the ten CPSP project sites to offer training, technical assistance and sustainability plans. School curricula have been matched to community needs and include Response, Lifelines, Sources of Strength, and American Indian Life Skills. Sisseton, which includes the Sisseton/Wahpeton Reservation, is one of the project sites and has a Native American population of 34.5% (vs. state average of 8.8%).

• Collaborate with DSS via task force planning meetings to improve suicide prevention across the state. Efforts include South Dakota Community Toolkit for Suicide Prevention, maintenance of the South Dakota Suicide Prevention website, and promotion of school policy and practice related to suicide prevention curricula.

• Contracted with SDAHO to begin receiving hospital discharge data specific to attempted suicides in an effort to further to support the need for additional suicide prevention efforts.

**c. Plan for the Coming Year**

• Partner with DSS to fund the HELP! Line Center with current projects and expansion for FY 2013 focusing on Native American youth. Efforts include placement of billboards promoting the Crisis Line across the state, including development of culturally sensitive Native American billboards to be placed in five reservation areas. Crisis Line texting will expand to six additional schools, three of which will be in tribal schools or in schools located on or near reservations.

• Support Garrett Lee Smith grantees as the funding cycle ends and communities complete sustainability plans and networking activities.

• Support and promote suicide prevention trainings and public awareness.

• Review available hospital discharge data on attempted suicides to provide additional information on the prevalence of suicide and need for additional efforts in suicide prevention.

**Performance Measure 17:** *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2007** | **2008** | **2009** | **2010** | **2011** |
|---|---|---|---|---|---|
| Annual Performance Objective | 90 | 87 | 87 | 87.8 | 87.9 |
| Annual Indicator | 86.6 | 86.4 | 87.8 | 87.7 | 85.8 |
| Numerator | 97 | 114 | 115 | 135 | 103 |

| | | | | | |
|---|---|---|---|---|---|
| Denominator | 112 | 132 | 131 | 154 | 120 |
| Data Source | | Birth Certificate | Birth Certificate | Birth Certificate | Birth Certificate |
| Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2012** | **2013** | **2014** | **2015** | **2016** |
| Annual Performance Objective | 87.9 | 88 | 88 | 88 | 88 |

**Notes - 2011**
2011 South Dakota birth certificate data.

**Notes - 2010**
2010 South Dakota birth certificate data. The 2006-2010 five-year trend of the percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates shows an almost flat trend. The data for this measure were collected using the South Dakota birth certificate data. While the rates tend to fluctuate slightly over the years, there are no significant differences between the years statistically.

**Notes - 2009**
2009 South Dakota birth certificate data

**a. Last Year's Accomplishments**
• Collaborated with DSVR to monitor the number of very low birth weight (VLBW) infants born at locations other than facilities with Level III nurseries.

• Partnered with Medicaid to assess all pregnant women seen at OFCH office sites for risks with the potential to affect pregnancy outcomes and provided case management to high-risk pregnant women.

• Provided education to pregnant clients seen at OFCH and delegate family planning sites to encourage/facilitate access to early and regular prenatal care.

• Provided Nurse Family Partnership (NFP) Bright Start Home Visiting Program services in Sioux Falls, Rapid City, and Pine Ridge.

• Submitted grant application to fund a statewide PRAMS.

• Supported Governor's Task Force on Infant Mortality meetings.

• Collaborated with GPTEC and tribal health representatives to share data and foster working relationships.

• Assessed service delivery at OFCH sites and developed local plans to enhance services to pregnant women.

**Table 4a, National Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Identify and address barriers to early and adequate prenatal care. | | | X | |
| 2. Collaborate with healthcare providers, hospital systems, March of Dimes, Perinatal Association, and other MCH partners to identify issues surrounding delivery of VLBW infants, including preterm labor. | | | | X |
| 3. Research alternative models of prenatal care to enhance quality of care. | | | | X |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

• Collaborating with DSVR to monitor the number of VLBW infants born at locations other than facilities with Level III nurseries.

• Collaborating GPTEC and tribal health representatives to share data and foster working relationships.

• Implementing recommendations and strategies of Governor's Task Force on Infant Mortality.

• Collaborating with physician, hospital systems, March of Dimes, Perinatal Association, and other MCH partners to identify issues surrounding delivery of VLBW infants, including preterm labor.

• Partnering with Medicaid to assess all pregnant women seen at OFCH sites for risks that have the potential to affect pregnancy outcomes and providing ongoing education/referral for those at-risk of preterm labor.

• Partnering with Medicaid to provide case management for high-risk pregnant women.

• Expanding services at OFCH offices to include monthly contact with all pregnant women on caseload to monitor health, provide education, and facilitate early referrals.

• Evaluate service delivery of OFCH programs to foster earlier client access, increase participation, and improve quality of care.

• Providing NFP Bright Start Home Visiting Program in Sioux Falls, Rapid City, and Pine Ridge.

• Implementing approved expansion for Home Visiting in Pine Ridge and at-risk community in northeast South Dakota.

• Contracting with vendor to develop statewide media campaign promoting early and adequate prenatal care.

• Partnering with DSS on Strong Start funding application.

**c. Plan for the Coming Year**

• Implement recommended strategies identified by Governor's Task Force on Infant Mortality to address barriers to early/adequate prenatal care.

• Collaborate with GPTEC and tribal health representatives to share data and foster working relationships.

• Provide education to women of childbearing age at OFCH and delegate family planning sites to encourage preconception health awareness, pregnancy planning and spacing, pregnancy awareness, and early and regular prenatal care.

• Collaborate with DSVR to monitor the number of VLBW infants born at locations other than facilities with Level III nurseries.

• Collaborate with physician, hospital systems, March of Dimes, Perinatal Association, and other MCH partners to identify issues surrounding delivery of VLBW infants, including preterm labor.

• Partner with Medicaid to assess all pregnant women seen at OFCH sites for risks that have the potential to affect pregnancy outcomes and provide ongoing education/referral for prenatal care, warning signs of pregnancy, signs of preterm labor, and behaviors that put the health of the mother and/or fetus at risk.

• Partner with Medicaid to provide case management for high-risk pregnant women to improve birth outcomes.

• Conduct ongoing assessment/evaluation of local plans expanding services to pregnant women at OFCH offices including monthly contact with all on caseload to monitor health, provide ongoing education regarding signs/symptoms of preterm labor and other complications of pregnancy, and facility early referrals.

• Provide NFP Bright Start Home Visiting Program in Sioux Falls, Rapid City, and Pine Ridge with expansion to additional at-risk tribal community.

• Expand Baby Care services to pregnant women in local agencies that currently provide WIC only.

• Evaluate service delivery of OFCH programs to develop local plans that foster increase participation, earlier access to service, and improved quality of care.

• Investigate potential funding sources for PRAMS.

• Support Centering Pregnancy pilot project in rural/frontier site.

• Partner with DSS to support Centering Pregnancy project pending award of federal funding.

• Support statewide media campaign educating women on early signs of pregnancy and importance of early and adequate prenatal care.

**Performance Measure 18:** *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2007** | **2008** | **2009** | **2010** | **2011** |
|---|---|---|---|---|---|

| | | | | | |
|---|---|---|---|---|---|
| Annual Performance Objective | 80 | 69.8 | 69.8 | 70 | 70 |
| Annual Indicator | 69.7 | 67.7 | 65.7 | 69.6 | 68.3 |
| Numerator | 8544 | 8179 | 7841 | 8208 | 8085 |
| Denominator | 12253 | 12074 | 11930 | 11795 | 11834 |
| Data Source | | Birth Certificate | Birth Certificate | Birth Certificate | Birth Certificate |
| Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied. | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2012** | **2013** | **2014** | **2015** | **2016** |
| Annual Performance Objective | 70.3 | 70.3 | 70.3 | 70.3 | 70.3 |

**Notes - 2011**
2011 South Dakota birth certificate data. Trimester of prenatal care was determined using date last normal menses began and date of first prenatal care visit.

**Notes - 2010**
2010 South Dakota birth certificate data. Trimester of prenatal carewas determined using date last normal menses began and date of first prenatal care visit. The 2006-2010 five-year trend of the percent of infants born to pregnant women receiving prenatal care beginning in the first trimester shows a slight downward trend. The data for this measure were collected using the South Dakota birth certificate data. The rate for 2009 is significantly different from all other years. The 2008 rate is significantly different from all years but 2006.

**Notes - 2009**
2009 South Dakota birth certificate data. Trimester of prenatal care for 2006 and after was determined using date last normal menses began and date of first prenatal care visit. Data for 2005 used the month prenatal care began provided on the birth certificate.

**a. Last Year's Accomplishments**
• Provided education to pregnant clients seen at OFCH and delegate family planning sites to encourage/facilitate access to early and regular prenatal care.

• Partnered with Medicaid to assess all pregnant women accessing services at OFCH offices for risks with the potential to affect pregnancy outcomes and provided ongoing education/referral and case management for those identified at high risk.

• Provided NFP Bright Start Home Visiting Program in Sioux Falls, Rapid City, and Pine Ridge.

• Developed state plan for expansion of Bright Start Home Visiting Program to at-risk communities through federal Affordable Care Act funding.

• Collaborated with GPTEC and tribal health representatives to share data and foster working relationships.

• Supported Governor's Task Force on Infant Mortality.

• Complied data regarding rates of pregnant women accessing early and adequate prenatal care to disseminate to MCH partners statewide.

• Submitted grant application for statewide PRAMS to enhance data collection (grant approved but not funded).

**Table 4a, National Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Maximize contacts with women of childbearing age to educate on preconception health, pregnancy planning/spacing, awareness of pregnancy, and the importance of early and adequate prenatal care. | | | X | |
| 2. Partner with Medicaid facilitate early and adequate prenatal care services for at-risk pregnant women. | | X | | |
| 3. Seek strategies to reduce access to care disparities in at-risk populations. | | | | X |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

• Implementing recommendations and strategies of Governor's Task Force on Infant Mortality.

• Providing education to pregnant clients seen at OFCH and delegate family planning sites regarding preconception health, pregnancy planning/spacing, awareness of pregnancy, and importance of early/adequate prenatal care.

• Implementing tracking at OFCH offices for timely follow-up with pregnant clients who report not accessing early/adequate prenatal care.

• Partnering with Medicaid to assess all pregnant women accessing OFCH offices for risks that have the potential to impact pregnancy outcomes, provide ongoing education/referral, and provide case management for those identified as high-risk

• Providing NFP Bright Start Home Visiting Program in Sioux Falls, Rapid City, and Pine Ridge.

• Implementing approved state plan to expand Home Visiting to at-risk tribal communities.

• Collaborating with GPTEC and tribal health representatives to share data and foster working relationships.

• Compiling and disseminating data on rates of pregnant women accessing early/adequate prenatal care.

• Investigating options for implementation of PRAMS.

• Adding preconception health education to Bright Start Welcome Boxes distributed to new parents.

• Contracting for development of statewide media campaign to increase awareness of

signs/symptoms of pregnancy and importance of early/adequate prenatal care.

• Partnering with DSS on Strong Start funding application.

**c. Plan for the Coming Year**

• Provide education to pregnant clients seen at OFCH and delegate family planning sites regarding preconception health, pregnancy planning/spacing, awareness of pregnancy, and importance of early/regular prenatal care.

• Partner with Medicaid to assess all pregnant women accessing OFCH offices for risks that have the potential to impact pregnancy outcomes, provide ongoing education/referral, and provide case management to high-risk pregnant women.

• Assess/evaluate local plans expanding services to pregnant women at OFCH offices to foster earlier access to services, increase participation, and improve quality of care.

• Monthly contact with all pregnant women on OFCH caseload to facilitate/monitor access to prenatal care, monitor health, provide ongoing education, and facilitate referrals.

• Provide NFP Bright Start Home Visiting Program in Sioux Falls, Rapid City, and Pine Ridge with expansion in Pine Ridge area and to at-risk tribal community in northeast South Dakota.

• Implement recommendations and strategies of Governor's Task Force on Infant Mortality to improve access to early/adequate prenatal care.

• Collaborate with GPTEC and tribal health representatives to share data and foster working relationships.

• Support statewide media campaign educating women on early signs of pregnancy and importance of early and adequate prenatal care.

• Support Centering Pregnancy pilot project in rural/frontier site.

• Partner with DSS to support Centering Pregnancy project pending award of federal funding.

• Collaborate with physician, hospital systems, March of Dimes, Perinatal Association, and other MCH partners to promote early/regular prenatal care.

• Investigate potential funding sources for PRAMS.

## D. State Performance Measures

**State Performance Measure 1:** *Percent of pregnancies which are unintended (mistimed or unwanted) and result in live birth or abortion.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2007** | **2008** | **2009** | **2010** | **2011** |
|---|---|---|---|---|---|
| Annual Performance Objective | 38 | 33.4 | 33.2 | 33.2 | 33 |

| | | | | | |
|---|---|---|---|---|---|
| Annual Indicator | 33.4 | 33.9 | 35.0 | 34.9 | 34.9 |
| Numerator | 4229 | 4256 | 4356 | 4333 | 4274 |
| Denominator | 12670 | 12568 | 12450 | 12427 | 12243 |
| Data Source | | Birth certificate | Birth certificate | Birth certificate | Birth certificate |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2012** | **2013** | **2014** | **2015** | **2016** |
| Annual Performance Objective | 33 | 33 | 33 | 33 | 33 |

**Notes - 2011**
Prorated 2010 South Dakota birth certificate data based on 2009 Perinatal Health Risk Assessment Survey data and 2010 South Dakota abortion data.

**Notes - 2010**
Prorated 2009 South Dakota birth certificate data based on 2009 Perinatal Health Risk Assessment Survey data and 2009 South Dakota abortion data. The 2006-2010 five-year trend of the percent of pregnancies which are unintended (mistimed or unwanted) and result in live birth or abortion shows an almost flat trend. While the rates tend to fluctuate slightly over the years only 2006 is significantly different from the other years.

**Notes - 2009**
Prorated 2098 South Dakota birth certificate data based on 2009 Perinatal Health Risk Assessment Survey data and 2009 South Dakota abortion data

**a. Last Year's Accomplishments**
• Provided family planning services to 9,444 clients in CY11. Of these clients, 6,998 were women over the age of 19 and 2,446 were adolescents aged 19 and under. Of the total clients, 7,492 were at or below 150 percent of poverty.

• Provided community education regarding reproductive health/family planning to 3,080 adults during CY11.

**Table 4b, State Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Provide family planning services to women at risk of unintended pregnancy. | | | X | |
| 2. Provide community education to individuals/groups regarding reproductive health and family planning. | | | X | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**
• Providing counseling, education, medical, and contraceptive services to women at risk of unintended pregnancy.

• Providing community education to individuals and groups regarding reproductive health/family planning topics.

**c. Plan for the Coming Year**
• Provide family planning services to populations at high risk for unintended pregnancy.

• Provide community education to individuals and groups regarding reproductive health and family planning topics.

• Collaborate with other agencies and offices with similar missions to address unintended pregnancy.

**State Performance Measure 2:** *Percent of singleton birth mothers who achieve a recommended weight gain during pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2007** | **2008** | **2009** | **2010** | **2011** |
|---|---|---|---|---|---|
| Annual Performance Objective | 22 | 29.5 | 29.7 | 29.7 | 30 |
| Annual Indicator | 29.5 | 30.9 | 30.7 | 28.8 | 28.5 |
| Numerator | 3505 | 3604 | 3574 | 3285 | 3277 |
| Denominator | 11876 | 11650 | 11623 | 11422 | 11490 |
| Data Source | | Birth certificate | Birth certificate | Birth certificate | Birth certificate |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2012** | **2013** | **2014** | **2015** | **2016** |
| Annual Performance Objective | 30 | 30 | 30 | 30 | 30 |

**Notes - 2011**
2011 South Dakota birth certificate data.

**Notes - 2010**
2010 South Dakota birth certificate data. The 2006-2010 five-year trend of the percent of singleton birth mothers who achieve a recommended weight gain during pregnancy shows an almost flat trend. There are no significant differences between the years.

**Notes - 2009**
2009 South Dakota birth certificate data

**a. Last Year's Accomplishments**
• Provided education to pregnant women on WIC, Baby Care, and Bright Start about proper nutrition and appropriate weight gain during pregnancy.

• Assisted pregnant women identify behavior changes and community resources to assist them in achieving a healthy diet and appropriate weight gain during pregnancy.

• Provided training and resources on nutrition and appropriate weight gain during pregnancy for

WIC, Bright Start, and Baby Care staff as well as other health care professionals.

• Collaborating with GPTEC and tribal health representatives to share data and foster working relationships.

• Widely distributed resources for health care providers to use when addressing healthy diet and appropriate weight gain with pregnant women.

• Supported "I Didn't Know My Weight Matters" website.

• Supported Governor's Task Force on Infant Mortality.

• Submitted application for PRAMS funding (application was approved but not funded).

• Partnered with Medicaid to assess pregnant women for risks that have the potential to impact pregnancy outcomes, including pre-pregnancy BMI, and provided ongoing education, referral for prenatal care, and case management for women identified at high risk for pregnancy complications.

**Table 4b, State Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Provide training/resources for healthcare providers who serve women of childbearing age on appropriate weight gain during pregnancy and risks associated with less than, or more than, recommended prenatal weight gain. | | | X | |
| 2. Assist pregnant women identify behavior changes and community resources that may assist them achieve appropriate weight gain during pregnancy. | | X | | |
| 3. Research alternative models of prenatal services that may enhance care. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

• Educating pregnant women on WIC, Baby Care, and Bright Start on healthy diet and appropriate weight gain during pregnancy and risks associated with less than or more than recommended prenatal weight gain.

• Assisting pregnant women identify behavior changes and community resources that may assist them achieve appropriate weight gain during pregnancy.

• Providing training opportunities for WIC, Baby Care, and Bright Start staff as well as other health care professionals on appropriate weight gain during pregnancy.

• Collaborating with GPTEC and tribal health representatives to share data and foster working relationships.

• Distributing prenatal weight gain tool kit resources to health care providers.

• Supporting the "I Didn't Know My Weight Matters" website.

• Develop new and revise previous DOH materials/resources to reflect current Institute of Medicine guidelines for prenatal weight gain.

• Researching alternative models of prenatal care.

• Partnering with Medicaid to assess all pregnant women accessing OFCH offices for risks with the potential to impact pregnancy outcomes including pre-pregnancy BMI.

• Partnering with Medicaid to provide case management of pregnant women identified at high risk.

• Providing Bright Start Home Visiting in Sioux Falls, Rapid City, and Pine Ridge.

• Implementing monthly weight check and prenatal education as part of brief health review with all women accessing OFCH sites to facilitate early referrals.

**c. Plan for the Coming Year**

• Support "I Didn't Know My Weight Matters" website.

• Support/facilitate distribution of prenatal weight gain education resources to health professionals.

• Provide education to women of childbearing age through OFCH program and delegate family planning agencies regarding healthy weight, nutrition, preconception health, pregnancy planning and awareness, and the importance of early and regular prenatal care.

• Educate pregnant women on WIC, Baby Care, and Bright Start on healthy diet and appropriate weight gain during pregnancy, and risks associated with less than or more than recommended prenatal weight gain.

• Collaborate with GPTEC and tribal health representatives to share data and foster working relationships.

• Partner with Medicaid to assess pregnant women for risks that have the potential to impact pregnancy outcome, including pre-pregnancy BMI, and provide ongoing education/referral for prenatal care.

• Partner with Medicaid to case manage high-risk pregnant women.

• Provide monthly contacts with pregnant women seen in OFCH offices to monitor weight and other health indicators, provide education, and facilitate early referrals.

• Assist pregnancy women identify behavior changes and community resources that may assist them achieve appropriate weight gain during pregnancy.

• Provide Bright Start Home Visiting services in Sioux Falls, Rapid City, expanded Pine Ridge project, and other high-risk community.

• Implement recommendations/strategies identified by Governor's Task Force on Infant Mortality to facilitate early entry by pregnant women into prenatal care.

• Support pilot project alternative model of prenatal care.

**State Performance Measure 3:** *Percent of pregnant women aged 18 through 24 who smoked during pregnancy*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2007** | **2008** | **2009** | **2010** | **2011** |
|---|---|---|---|---|---|
| Annual Performance Objective | | | | | 25.8 |
| Annual Indicator | | 27.6 | 28.1 | 25.8 | 26.6 |
| Numerator | | 1099 | 1096 | 947 | 946 |
| Denominator | | 3982 | 3906 | 3675 | 3557 |
| Data Source | | Birth certificate | Birth certificate | Birth certificate | Birth certificate |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2012** | **2013** | **2014** | **2015** | **2016** |
| Annual Performance Objective | 25 | 25 | 25 | 25 | 25 |

**Notes - 2011**
2011 South Dakota birth certificate data.

**Notes - 2010**
2009 South Dakota birth certificate data. The 2006-2010 five-year trend of the percent of pregnant women age 18 through 24 years who smoked during pregnancy. shows a slight downward trend. The data for this measure were obtained from the birth certificate data. Even though the percentages are gradually decreasing over the five years the 2007 data are significantly different from the 2010 data.

**Notes - 2009**
2009 South Dakota birth certificate data

**a. Last Year's Accomplishments**
• Worked with DSS to include tobacco prevention messaging in Bright Start Welcome Boxes.

• Risk assessed all mothers in the Baby Care and Bright Start Home Visiting Program for smoking behaviors three months prior to pregnancy as well as during pregnancy.

• Provided cessation services via the QuitLine at no cost to the caller.

**Table 4b, State Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Risk assess all mothers regarding smoking behaviors and exposure to secondhand smoke. | | | X | |
| 2. Provide educational materials and resources to mothers regarding effects of tobacco use on them, their developing fetus, and their other children. | | | X | |

| | | | | |
|---|---|---|---|---|
| 3. Make referrals as needed for smoking cessation services as well as strategies to limit or eliminate exposure to secondhand smoke. | | X | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

• Risk assessing all mothers regarding smoking behaviors and exposure to secondhand smoke.

• Providing educational materials and resources to mothers regarding effects of tobacco use on them, their developing fetus, and their other children.

• Making referrals as needed for smoking cessation services as well as strategies to limit or eliminate exposure to secondhand smoke.

• Redesigning brochures regarding smoking during pregnancy and secondhand smoke exposure; created new public education campaign "What would you do to save your child's life?" for TV, radio and print media targeting low income and Native American mothers.

**c. Plan for the Coming Year**

• Provide secondhand smoke materials for the Bright Start Welcome Boxes.

• Risk assess all mothers in the Baby Care and Bright Start Home Visiting Program for smoking behaviors three months prior to pregnancy as well as during pregnancy.

• Provide cessation services via the QuitLine at no cost to the caller; expanded eligibility for priority populations including pregnant and nursing mothers.

• Collaborate with DSS to promote safe sleep habits and eliminate infant's exposure to secondhand smoke. This collaborative effort is the result of the Governor's Task Force on Infant Mortality.

• Provide education and cessation materials to health care providers in South Dakota counties with a high prevalence for smoking during pregnancy.

• Conduct statewide secondhand smoke public education campaign specifically targeting pregnant women and mothers of young children.

## State Performance Measure 4: *Percent of infants exposed to secondhand smoke.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2007** | **2008** | **2009** | **2010** | **2011** |
|---|---|---|---|---|---|
| Annual | 14.5 | 9.4 | 9.4 | 9.3 | 9.3 |

| | | | | | |
|---|---|---|---|---|---|
| Performance Objective | | | | | |
| Annual Indicator | 9.4 | 9.4 | 8.1 | 8.1 | 8.1 |
| Numerator | 84 | 84 | 58 | 58 | 58 |
| Denominator | 896 | 896 | 720 | 720 | 720 |
| Data Source | | SD Perinatal Health Risk Assessment | SD Perinatal Health Risk Assessment | SD Perinatal Health Risk Assessment | SD Perinatal Health Risk Assessment |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2012** | **2013** | **2014** | **2015** | **2016** |
| Annual Performance Objective | 9.2 | 9.2 | 9.2 | 9.2 | 9.2 |

**Notes - 2011**
2009 South Dakota Perinatal Health Risk Assessment Survey data.A 2011 Perinatal Health Risk Assessment Survey was not conducted.

**Notes - 2010**
2009 South Dakota Perinatal Health Risk Assessment Survey data. The 2006-2010 five-year trend of the percent of infants exposure to secondhand smoke shows a downward trend. The data for this measure were obtained from the South Dakota Perinatal Health Risk Assessment Survey that is conducted every other year. Even though the percents are significantly different between the survey conducted in 2005-2006 and the others caution should be taken when drawing conclusions until more years of survey data are collected, future monitoring of the data will reveal the direction this measure is taking.

**Notes - 2009**
2009 South Dakota Perinatal Health Risk Assessment Survey data

**a. Last Year's Accomplishments**
• Conducted secondhand smoke public education campaign.

• Provided tobacco prevention messaging in Bright Start Welcome Boxes.

• Risk assessed all mothers in the Baby Care and Bright Start Nurse Home Visiting programs for smoking behaviors three months prior to pregnancy as well as during pregnancy.

• Provided education, resources, and referrals to all moms who indicate either smoking behaviors or exposure to secondhand smoke within their environment.

• Strongly recommended smoking cessation or limiting/eliminating exposure to secondhand smoke strategies to assist those moms that have quit smoking to remain tobacco free.

• Provided cessation services via the QuitLine at no cost to the caller.

**Table 4b, State Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Risk assess all mothers regarding smoking behaviors and exposure to secondhand smoke. | | | X | |

| | | | | |
|---|---|---|---|---|
| 2. Provide educational materials and resources to mothers regarding effects of tobacco use on them, their developing fetus, and their other children. | | | X | |
| 3. Make referrals as needed for smoking cessation strategies as well as strategies to limit or eliminate exposure to secondhand smoke. | | X | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

• Working with DSS staff to include tobacco prevention messaging in Bright Start Welcome Boxes.

• Risk assessing all mothers in the Baby Care and Bright Start Nurse Home Visiting programs for smoking behaviors three months prior to pregnancy as well as during pregnancy.

• Providing cessation services via the QuitLine at no cost to the caller.

• Created new public education campaign "What Would You Do To Save Your Child's Life?" for TV, radio and print media targeting low income and Native American mothers.

**c. Plan for the Coming Year**

• Provide secondhand smoke materials for the Bright Start Welcome Boxes.

• Risk assess all mothers in the Baby Care and Bright Start Nurse Home Visiting programs for smoking behaviors three months prior to pregnancy as well as during pregnancy.

• Collaborate with DSS to promote safe sleep habits and eliminate infant's exposure to secondhand smoke. This collaborative effort is the result of the Governor's Task Force on Infant Mortality.

• Provide cessation services via the QuitLine at no cost to the caller; have expanded eligibility for priority populations in the state, including pregnant and nursing mothers.

• Redesign brochures regarding smoking during pregnancy and secondhand smoke exposure.

• Provide education and cessation materials to health care providers in South Dakota counties with a high prevalence of smoking during pregnancy.

• Conduct statewide secondhand smoke public education campaign specifically targeting pregnant women and mothers of young children.

**State Performance Measure 6:** *Percent of school-aged children and adolescents with a Body Mass Index (BMI) at or above the 95th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| Annual Objective and Performance Data | 2007 | 2008 | 2009 | 2010 | 2011 |
|---|---|---|---|---|---|
| Annual Performance Objective | 15.8 | 16.2 | 16 | 15.8 | 15.6 |
| Annual Indicator | 16.3 | 16.3 | 16.6 | 16.0 | 16.0 |
| Numerator | 6777 | 6036 | 6674 | 6551 | 6551 |
| Denominator | 41579 | 37028 | 40202 | 40945 | 40945 |
| Data Source | | SD School Height-Weight | SD School Height-Weight | SD School Height-Weight | SD School Height-Weight |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2012** | **2013** | **2014** | **2015** | **2016** |
| Annual Performance Objective | 15.4 | 15.3 | 15.3 | 15.3 | 15.3 |

**Notes - 2011**
2009/2010 South Dakota school year School Height and Weight data.

**Notes - 2010**
2009/2010 South Dakota school year School Height and Weight data. The 2006-2010 five-year trend of the decrease the percent of school-aged children and adolescents age 5 through 19 years with a BMI at or above the 95th percentile shows a slight downward trend. While the rates tend to fluctuate slightly over the years only 2006 is significantly different from the 2010 data

**Notes - 2009**
2008/2009 South Dakota school year School Height and Weight data.

**a. Last Year's Accomplishments**
• Collected and analyzed school height and weight data for the 2010-11 school year.

• Received data from 223 schools on 40,945 students for the 200-10 school year; data collected showed 16.0% of South Dakota students were obese (vs. 16.6% the previous two year) (BMI for age 95th percentile and above) and 32.7% are overweight or obese.

• Provided 39 balance beam scales and measuring boards to schools to improve school height-weight data quality and assist schools who wish to participate in the project but can't due to lack of equipment.

• Collaborated with partners to implement strategies in the State Plan to Prevent Obesity and Other Chronic Diseases especially those objectives and strategies focused on parents, caregivers, schools, and youth organizations.

• Provided print materials on child obesity to schools and others who serve youth and made materials available on the DOH website.

• Collaborated with GFP to develop backpacks of resources for childcare providers to encourage physical activity in the outdoors.

• Co-sponsored special supplement of SDSMA medical journal on obesity prevention and treatment.

• Provided grants to five dietitians to attend the Pediatric Weight Management course and achieve Commission on Dietetic Registration (CDR) certification to build obesity prevention and treatment infrastructure.

• Collaborated with Sioux Falls School District and area healthcare providers to intervene with students identified with weight issues.

• Develop model health concessions policy and promoted to non-school youth organizations such as club sports.

• Co-sponsored SDSU Nutrition Seminar.

**Table 4b, State Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Collect, analyze, and interpret school height/weight data and distribute to health/education providers and promote computerized data collection system. | | | | X |
| 2. Provide 14 balance beam scales and measuring boards to schools to improve school height-weight data. | | | | X |
| 3. Promote model healthy concessions policy to non-school youth organizations and collaborate to expand into schools (pilot in 7 schools). | | | | X |
| 4. Collaborate with partners to implement strategies in the State Plan to Prevent Obesity and Other Chronic Diseases. | | | | X |
| 5. Provide print materials on child obesity to schools and others who serve youth and make materials available on the DOH website. | | | X | |
| 6. Collaborate with Coordinated School Health, Healthy SD and Discovery Center to develop a South Dakota Harvest of the Month website to go along with the 36 months of Fruits and Vegetables curriculum. | | | | X |
| 7. Provide grants for registered dietitians to obtain CDR certificate of training in pediatric weight management. | | | X | |
| 8. Collaborate to assess poor fruit/vegetable consumption by South Dakotans. | | | | X |
| 9. Collaborate with Sioux Falls School District and area healthcare providers to intervene with students identified with weight issue. | | X | | |
| 10. Collaborate with GFP to provide resources for out-of-school time programs to promote physical activity in the outdoors. | | | X | |

**b. Current Activities**

• Using the CSHP electronic newsletter "NewsInfused" to share information with public, private, tribal, and BIA schools in the state.

• Co-sponsoring SDSU Nutrition Seminar.

• Contracting with Educational Service Agency to manage a pilot project for educators on effective health and physical education curriculum, instruction, and assessment through the development of a regional-based training plan.

• Contracting for further analysis of 14 years of school height-weight data.

**c. Plan for the Coming Year**
• Provide nutrition and physical activity expertise.

• Collect, analyze, and interpret available height-weight data for school-aged children and distribute information to appropriate health and education providers in an effort to reduce the percent of overweight children and adolescents.

• Collaborate on interventions to reverse the decline in fruit and vegetable consumption by South Dakotans of all ages including expansion of Harvest of the Month to communities and worksites.

• Implement 2010 Nutrition and Physical Activity State Plan to Prevent Obesity and Other Chronic Diseases objectives and activities to address obesity in schools.

• Provide grants for registered dietitians to receive certificate in pediatric weight management.

• Collaborate with Sioux Falls School District and area healthcare providers to provide interventions to students with weight issues.

• Collaborate with GFP to promote Trail Trek signs in South Dakota state and local parks to encourage increased outdoor physical activity, particularly during winter months.

**State Performance Measure 7:** *Percent of high school youth who report having smoked cigarettes in the past 30 days.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2007** | **2008** | **2009** | **2010** | **2011** |
|---|---|---|---|---|---|
| Annual Performance Objective | 28 | 24.7 | 24.5 | 24.5 | 24.4 |
| Annual Indicator | 24.7 | 24.7 | 23.2 | 23.2 | 23.1 |
| Numerator | 10757 | 10757 | 10000 | 10000 | 9894 |
| Denominator | 43550 | 43550 | 43104 | 43104 | 42830 |
| Data Source | | YRBS | YRBS | YRBS | YRBS |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2012** | **2013** | **2014** | **2015** | **2016** |
| Annual Performance Objective | 24.4 | 24.3 | 24.3 | 24.3 | 24.3 |

**Notes - 2011**
2010/2011 South Dakota school enrollment based on 2011 YRBS data.

**Notes - 2010**
2008/2009 South Dakota school enrollment based on 2009 Youth Risk Behavior Survey data. The 2006-2010 five-year trend of the percent of high school youth who self-report tobacco use in the past 30 days shows a gradual downward trend. Even though the percents are gradually decreasing over the years 2006 through 2010, none of the data are significantly differ than the other. Data for this indicator are from the YRBS.

**Notes - 2009**
2008/2009 South Dakota school enrollment based on 2009 Youth Risk Behavior Survey data

**a. Last Year's Accomplishments**
• Served on DSS Alcohol and Drug Abuse Council.

• Provided QuitLine materials to CHN offices to facilitate efforts to inform parents and the community about the health effects of smoking, secondhand smoke and spit tobacco.

• Collaborated with other state agencies to administer the Youth Risk Behavior Survey (YRBS) in South Dakota high schools.

• Provided QuitLine referral materials to DOH field offices, medical providers, tribal health, and other partners.

• Utilized Prevention Resource Centers (PRCs) to distribute educational materials regarding tobacco use.

• Conducted public education campaign targeting youth and focusing on the effects of tobacco use and secondhand smoke.

• Encouraged/supported participation of schools and youth in local tobacco prevention coalitions.

• Provided statewide cessation services via the QuitLine at no cost to the caller.

• Partnered with DOE to support and incorporate tobacco prevention education in schools.

• Partnered with Tobacco Technical Assistance Center, GPTCHB, and committee of tribal members to create a policy-based toolkit for tribal K-12 schools.

• Created "Find Your Power" campaign to increase the number of Native Americans who quit abusing commercial tobacco products. Messaging for campaign was created using input from series of focus group with tribal members and health providers. Partnered with national renowned Lakota artist Don Montileaux to create culturally significant graphics to compliment campaign materials.

• Expanded TCP Advisory Committee to include a member of the GPTCHB Health Promotion Program staff.

• Worked with GPTCHB to write a mini-grant to the South Dakota Comprehensive Cancer Control Program's Tobacco Prevention Workgroup to purchase incentive items with the "Find Your Power" logo to support smoke-free pow-wows, sundances, and other tribal ceremonies.

• Attended A PROMISE: Reclaiming the Health of Our Tribal Nations national conference in Tempe AZ with GPTCHB to present on collaborative efforts to impact chronic disease in South Dakota's Native American population.

• Provided resources for the Bright Start Welcome Box about the dangers of exposing newborns and children to secondhand smoke.

**Table 4b, State Performance Measures Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Sponsor community coalitions working on tobacco prevention at the local level. | | | | X |
| 2. Encourage and support comprehensive tobacco-free policies in schools. | | | X | |
| 3. Conduct countermarketing campaigns at state and local level. | | | X | |
| 4. Provide statewide telephone-based tobacco cessation services at no cost to the caller. | | | X | |
| 5. Utilize data from YRBS and Youth Tobacco Survey to refine program activities to address specific populations with higher | | | | X |

| | | | | |
|---|---|---|---|---|
| tobacco use including high school and middle school students. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

• Providing cessation services via the QuitLine at no cost to the caller.

• Collaborating with DOE to sponsor implementation of tobacco prevention education (LifeSkills) in South Dakota schools.

• Surveyed all K-12 schools to assess comprehensiveness of tobacco policies; each participating school received a report highlighting strengths and weaknesses of current policies as well as recommendations for improvement.

• Providing technical assistance and resources to DOH staff, community groups, schools, parents, health care providers, and others working on tobacco prevention.

• Conducting countermarketing/public education campaigns targeting youth.

• Providing Teens Against Tobacco Use (TATU) training to various groups of students around the state.

• Offering mini-grants to fund TATU and Not On Tobacco (NOT) programs in K-12 public, private, and tribal schools.

• Providing audiovisual messages to CHN offices and DSS Medicaid field offices to deliver tobacco prevention and cessation messaging to clients.

• Providing a web-based tobacco prevention program for youth and young adults (www.rethinktobacco.com).

• Providing a new web-based tobacco cessation counseling service for adults (www.sdquitline.com).

**c. Plan for the Coming Year**

• Provide cessation services via the QuitLine at no cost to the caller; have expanded eligibility for priority populations to include youth and young adults.

• Distribute grant funds for school and community partnerships to decrease tobacco use among children and young adults.

• Collaborate with DOE to conduct the YRBS.

• Collaborate with DOE and DSS to support LifeSkills training and curriculum for schools.

• Contract for a statewide trainer position to expand and provide TATU and NOT training to students as well as manage mini-grants to support TATU/NOT program activities in K-12 schools.

**State Performance Measure 8:** *Accidental death rate (per 100,000) among adolescents aged 15 through 19 years*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

| **Annual Objective and Performance Data** | **2007** | **2008** | **2009** | **2010** | **2011** |
|---|---|---|---|---|---|
| Annual Performance Objective | | | | | 39.3 |
| Annual Indicator | | 41.7 | 56.3 | 39.9 | 24.2 |
| Numerator | | 24 | 33 | 23 | 14 |
| Denominator | | 57540 | 58571 | 57628 | 57916 |
| Data Source | | Death certificate | Death certificate | Death certificate | Death certificate |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2012** | **2013** | **2014** | **2015** | **2016** |
| Annual Performance Objective | 39.3 | 39 | 39 | 38.5 | 38.5 |

**Notes - 2011**
2011 South Dakota death certificate data. Rate based on 2009 South Dakota population estimate.

**Notes - 2010**
2010 South Dakota death certificate data. Rate based on 2009 South Dakota population estimate. The 2006-2010 five-year trend to reduce the accidental death rate per 100,000 among adolescents age 15 through 19 years shows an almost flat trend. While the rates tend to fluctuate between the years, there are no statistically significant differences between the years. The numbers used to calculate these rates are relatively small and tend to yield large confidence intervals.

**Notes - 2009**
2009 South Dakota death certificate data. Rate based on 2009 South Dakota population estimate.

**a. Last Year's Accomplishments**
• Supported activities and media campaigns to raise awareness and promote use of seatbelts (i.e., Thanksgiving Safe Driving; May Mobilization Seat Belt Campaign; Buckle Up Bulldogs Youth Seat Belt Effort; SADD Youth Group trainings; SD Safety Council Alive at 25; SD Highway Patrol Rollover Simulator).

• Participated in Traffic Safety Conference to network and identify safety concerns and opportunities.

• Collaborated with prevention agencies to address underage drinking, drug use and impaired driving activities and campaigns such as Red Ribbon; mock crashes; Miss South Dakota's impaired driving presentations; Halloween, December and St. Patrick's Day Impaired Driving; Parents Matter; South Dakota Prevention Network school presentations; From the HEART Impaired Driving Program.

• Partnered with DPS to purchase an Impaired Driving Simulator (for a total of 3 simulators), trailer, and projector/screen used in presentations to high school students across the state.

• Supported the Tribal Traffic Safety Conference that examined safety concerns on Tribal Lands and identified potential ways to resolve issues.

• Participated on a technical panel as part of the Driver Education Research Project to identify and recommend the most effective driver education program for young drivers.

**Table 4b, State Performance Measures Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Collaborate with local advocates, law enforcement, and emergency responders to raise awareness and promote the use of seatbelts. | | | X | |
| 2. Participate in Transportation Safety Conference to network and identify ways to improve highway safety. | | | | X |
| 3. Collaborate with prevention agencies to address underage drinking, drug use, and impaired driving. | | | X | |
| 4. Promote and collaborate in a variety of youth distracted driving awareness activities. | | | | X |
| 5. Partner with DPS on development and implementation of teen highway safety projects. | | | | X |
| 6. Participate in Children's Safety Network workgroup to network with other states on ways to prevent unintentional injuries. | | | | X |
| 7. Support South Dakota's Teen Driving Task Force to examine and review data, laws, practices, and policies related to teen driving education, licensing, and safety. | | | | X |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

**b. Current Activities**

• Promoting numerous statewide media campaigns as well as local events for seatbelt use and impaired and distracted driving including the Oglala Sioux Tribe's Don't Shatter the Dream Campaign that addresses seat belt use, speeding and impaired/ distracted driving on the Pine Ridge Reservation.

• Supporting Parents Matter prevention trainings and activities to address underage drinking and drug use such as prevention education in schools and Reality Parties.

• Promoting SADD presentations and statewide SADD Conference promoting seatbelt use and impaired driving.

• Participating in the Transportation Safety Conference to share programs and networking opportunities related to highway safety including drivers' education, impaired or distracted driving prevention, and motorcycle safety.

• Collaborating on the Driver Simulator Program which has now served 1,347 participants and is collecting information to do possible longitudinal data analysis in the future. The simulator has been utilized in at least one high school near a reservation and was demonstrated at the Tribal Safety Summit.

• Participating on the newly formed Children's Safety Network workgroup to network with other states to address childhood unintentional injury issues.

• Supporting the South Dakota Teen Driving Task Force which will provide recommendations for

improving teen driving safety to the 2013 South Dakota Legislature.

**c. Plan for the Coming Year**

• Promote statewide media campaigns and state and local activities related to seatbelt use, impaired/distracted driving, and drinking and drug use.

• Attend the Transportation Safety Conference, and the Tribal Traffic Safety Conference.

• Continue partnership with DPS and other agencies related to teen safety projects with emphasis on Tribal collaborations.

• Support recommendations of the South Dakota Teen Driving Task Force.

• Continue participation in Children's Safety Network workgroup.

## E. Health Status Indicators

Ongoing review of the Health Status Indicators provides the DOH and MCH program with information on the state's population to assist in directing public health efforts. The review of the indicators is one of many pieces of ongoing data efforts that allow the MCH program to analyze and evaluate current programs and services, identify gaps in services, review goals and objectives, and enhance collaboration with partners, if necessary. The MCH team uses this data to examine existing capacity and assist programs align efforts not only within the MCH program by within the overall DOH 2020 Initiative.

The South Dakota MCH surveillance system utilizes indicators such as demographics, education, income, WIC participation, health status of mom and baby, prenatal care, pre/post health behaviors, tobacco use, and family support to drive policy and programs throughout the state. Surveillance systems used include Behavioral Risk Factor Surveillance System (BRFSS), Tribal PRAMS, Youth Tobacco Survey, YRBS, Medicaid, hospital discharge, birth/death certificates, Perinatal Health Risk Assessment Survey, oral health survey, and Dakota Smiles Mobile Dental Program. South Dakota uses the surveillance system data for: (1) program planning; (2) program implementation; (3) assessing program effectiveness; and (4) improving program accountability.

## F. Other Program Activities

Preventive/Primary Care Services for Pregnant Women, Mothers and Infants -- MCH perinatal program staff at the state, regional, and community level provide services, offer technical assistance, and partner with other agencies to improve the health of pregnant women, mothers, and infants and impact pregnancy outcomes. Staff in the community provide direct case management and education services, link clients with appropriate resources, and collaborate with public and private partners to assure access to services.

Nurse home visiting programs modeled after the David Olds model are available in Rapid City, Sioux Falls, and Pine Ridge. Quality of services is assured through formalized activities at the state and local level. Client education materials are made available for both agency staff and private partners to utilize in the provision of services to this population. Training for professionals is provided directly or through collaboration with other agencies.

/2012/ The Nurse Family Partnership (NFP) home visiting program is currently provided to high-

risk pregnant women and families in Rapid City, Sioux Falls, and Pine Ridge. The MIECHVP grant provide the opportunity to expand the NFP program to the remaining communities on the Pine Ridge Reservation as well as the surrounding counties identified as high-risk. As additional funding is secured, the home visiting program will be expanded to other identified high risk reservation counties. //2012//
***/2013/ The NFP home visiting program continues to be provided at Sioux Falls, Rapid City, and Pine Ridge. The MIECHVP dollars have allowed the DOH to expand to an additional site on the Pine Ridge reservation at Kyle. Staff recruitment of one additional home visitor and one site coordinator continues for the expansion site. The DOH is beginning to plan for implementation of a new home visiting site at the Sisseton-Wahpeton Reservation. With the implementation of the MIECHVP home visiting sites, the DOH has developed an approved Benchmark and Continuous Quality Improvement Plan to monitor quality of the program and movement toward the established benchmarks of the MIECHVP program.//2013//***

Preventive/Primary Care Services for Children and Adolescents -- DOH staff at the state, regional, and community level provide services, offer technical assistance, and partner with other agencies to improve the health of children and adolescents. Staff in the community provide developmental/social-emotional screening, immunizations, school screenings, health fairs, health education for school-age children, and parent education and participate locally on various advisory groups such as child protection teams, coordinated school health councils, interagency teams, etc. They share information and resources to facilitate referral to programs (i.e., SCHIP, food stamps, and heating assistance) and work with state agencies, organizations, communities, and partners to provide technical assistance to promote MCH programs. Program staff also participate on several workgroups facilitated by other state agencies.

Services for CYSHCN -- State CSHS staff participate in numerous activities to enhance the capacity of the health and related service systems to identify and refer CYSHCN in a timely and efficient manner. Networking and public education activities are ongoing by program staff. These activities also provide opportunities to discuss service delivery and other issues impacting CYSHCN. MCH funds assist in the provision of respite care services for CYSHCN, with staff also assisting in the application process as appropriate. The CSHS program director also represents the program on the State Interagency Coordinating Council for Birth to Three and SDPC Family to Family Advisory Council as well as various other workgroups and committees at the state level.

## G. Technical Assistance

The MCH program is committed to assuring all MCH populations in the state receive the highest quality care and have optimal health. The MCH program is seeking technical assistance in two areas: (1) assessing the impact of national health care reform legislation on MCH programs and populations in South Dakota; and (2) examining hospital practices related to promoting breastfeeding by mothers at hospital discharge.
/2012/ The MCH program has currently not identified any technical assistance needs for the FY2012 MCH block grant. As needs are identified, the MCH program will seek technical assistance. //2012//
***/2013/ The MCH program applied for and was awarded technical assistance to bring in Sarah Verbiest from the University of North Carolina's Center for Maternal and Infant Health to present on "Working Together to Improve Women's Health and Birth Outcomes in South Dakota". The presentation was an overview of the Life Course Theory and steps to move forward with implementing it into MCH practice. Approximately 230 MCH partners were in attendance for the presentation. The MCH program has currently not identified any technical assistance needs for the FY2013 MCH block grant. As needs are identified, the MCH program will seek technical assistance. //2013//***

# V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

### Form 3, State MCH Funding Profile

| | FY 2011 | | FY 2012 | | FY 2013 | |
|---|---|---|---|---|---|---|
| | **Budgeted** | **Expended** | **Budgeted** | **Expended** | **Budgeted** | **Expended** |
| **1. Federal Allocation** *(Line1, Form 2)* | 2252548 | 107935 | 2236264 | | 2236264 | |
| **2. Unobligated Balance** *(Line2, Form 2)* | 0 | 2078861 | 0 | | 0 | |
| **3. State Funds** *(Line3, Form 2)* | 1718000 | 1577878 | 1718000 | | 1718000 | |
| **4. Local MCH Funds** *(Line4, Form 2)* | 250000 | 250000 | 400000 | | 400000 | |
| **5. Other Funds** *(Line5, Form 2)* | 0 | 0 | 0 | | 0 | |
| **6. Program Income** *(Line6, Form 2)* | 472000 | 199190 | 300000 | | 300000 | |
| **7. Subtotal** | 4692548 | 4213864 | 4654264 | | 4654264 | |
| **8. Other Federal Funds** *(Line10, Form 2)* | 16859960 | 21555800 | 18964432 | | 18516582 | |
| **9. Total** *(Line11, Form 2)* | 21552508 | 25769664 | 23618696 | | 23170846 | |

### Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

| | FY 2011 | | FY 2012 | | FY 2013 | |
|---|---|---|---|---|---|---|
| **I. Federal-State MCH Block Grant Partnership** | **Budgeted** | **Expended** | **Budgeted** | **Expended** | **Budgeted** | **Expended** |
| **a. Pregnant Women** | 764933 | 349773 | 497075 | | 395612 | |
| **b. Infants < 1 year old** | 375000 | 141080 | 222939 | | 186170 | |
| **c. Children 1 to 22 years old** | 1500000 | 1870402 | 1981256 | | 2038568 | |
| **d. Children with** | 1617067 | 1418364 | 1530774 | | 1582450 | |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Special Healthcare Needs** | | | | | | |
| **e. Others** | 300000 | 292824 | 287711 | | 293219 | |
| **f. Administration** | 135548 | 141421 | 134509 | | 158245 | |
| **g. SUBTOTAL** | 4692548 | 4213864 | 4654264 | | 4654264 | |
| **II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).** | | | | | | |
| **a. SPRANS** | 0 | | 0 | | 0 | |
| **b. SSDI** | 93713 | | 97260 | | 113470 | |
| **c. CISS** | 0 | | 0 | | 0 | |
| **d. Abstinence Education** | 0 | | 122552 | | 116169 | |
| **e. Healthy Start** | 0 | | 0 | | 0 | |
| **f. EMSC** | 0 | | 0 | | 0 | |
| **g. WIC** | 15351728 | | 16556219 | | 15666260 | |
| **h. AIDS** | 0 | | 0 | | 0 | |
| **i. CDC** | 216849 | | 216649 | | 213113 | |
| **j. Education** | 0 | | 0 | | 0 | |
| **k. Home Visiting** | 0 | | 0 | | 1000000 | |
| **k. Other** | | | | | | |
| **PREP** | 0 | | 250000 | | 250000 | |
| **Title X** | 1197670 | | 1086669 | | 1157570 | |
| **MIECHVP** | 0 | | 635083 | | 0 | |

**Form 5, State Title V Program Budget and Expenditures by Types of Services (II)**

| | FY 2011 | | FY 2012 | | FY 2013 | |
|---|---|---|---|---|---|---|
| | **Budgeted** | **Expended** | **Budgeted** | **Expended** | **Budgeted** | **Expended** |
| **I. Direct Health Care Services** | 328478 | 517882 | 465426 | | 558512 | |
| **II. Enabling Services** | 656957 | 548102 | 744682 | | 698140 | |
| **III. Population-Based Services** | 1689317 | 1491142 | 1628992 | | 1582450 | |
| **IV. Infrastructure Building Services** | 2017796 | 1656738 | 1815164 | | 1815162 | |
| **V. Federal-State Title V Block Grant Partnership Total** | 4692548 | 4213864 | 4654264 | | 4654264 | |

## A. Expenditures

Activities performed by MCH program and field staff that provide services funded by the MCH block grant are accounted for by a daily time study. The time study includes funding codes that reflect the population being served (i.e., child/adolescent, pregnant women, mothers and infants, and CYSHCN). Function codes determine if the service was direct, enabling, population-based, or infrastructure. Examples of this are developmental screening, immunization administration, travel to provide services, training, networking, quality assurance, and case management.

The budget amounts reflect anticipated activities of program and field staff but actual expenditures can vary based on the state economy and public health events (i.e., outbreaks, natural disasters). South Dakota law prohibits deficit spending so the Governor and state Legislature control the spending of general funds that in turn affect dollars that are available for

MCH block grant match.

## B. Budget

MCH block grant funds have historically been used to address DOH priorities as outlined in the needs assessment and annual plan of the MCH block grant application. The comprehensive needs assessment process assists the DOH in setting priorities for resource allocation. The amount of funding allocated to MCH services is determined as part of the state budget process that includes development of the budget by the DOH, interim approval by the Bureau of Finance and Management (BFM) and Governor's Office, and final approval by the state Legislature.

The budget outlines areas for which Title V funds will be allocated. Development of the budget complies with the "30-30" requirement for primary and preventive care and special health care needs for children and adolescents and is consistent with the requirements to limit administrative costs to no more than ten percent. The DOH maintains the overall level of funds for MCH at the level established in FFY 1989.

Appropriation of general funds for MCH state match is at the discretion of the Legislature, Governor's Office, and DOH. State match funding sources are state funds (including general funds appropriate by the Legislature), local match, program income, and other sources. No foundation or other private funding is currently available or utilized. The level of funds utilized from each match source varies from one year to the next based on availability of funds and the state's allocation process. Increasing inflationary costs have depleted revenue reserves within the DOH and the state as a whole and required shifts in match fund sources.

Budget development is subject to rules and requirements set by BFM dictating both the process and content of the budget, including availability of funds and limitations on authorization levels. State MCH programs were first required to use the current format of reporting budgets and expenditures (including levels of the pyramid) in FFY 1999. Since that time, South Dakota has been refining the budget development and expenditure process to meet both state and federal rules and requirements. The DOH continues to work to move to accounting programs that more easily reflect population group and pyramid level reporting requirements. The DOH and other state agency partners are reviewing potential grant opportunities in the area of maternal, infant, and childhood home visiting, abstinence, and Personal Responsibility Education program. /2012/ The DOH has received funding for the MIECHVP, Abstinence, and PREP and continues to partner with other state agencies to plan and implement services related to these grants. //2012// ***/2013/ The DOH continues to receive MIECHVP, Abstinence, and PREP funding and continues to partners with other state and local agencies to plan and implement services related to these grants. //2013//***
All of these opportunities would impact the MCH population in South Dakota if received.

Direct Health Services: A portion of the MCH block grant has traditionally been allocated to health service delivery (state-employed CHNs and nutritionists/dietitians) based on DOH time study data. For Alliance sites, services are contracted out to private agencies with DOH staff providing technical assistance to communities and maintaining its role of assessment, assurance, and evaluation. DOH time study data tracks actual time spent delivering MCH services and activities. CHNs, dietitians, and nutritionists provide MCH services statewide to assure a local delivery system of quality public health services. The budget reflects the projected allocations to assure provision of postpartum/MCH home visits and family planning services. This allocation of funds enables a system of service delivery to assure essential health care services are available in rural areas of the state. The DOH continues to move to reduction of direct health care services when appropriate.

Enabling Services: MCH block grant funds support activities to enhance access to care and assist consumers receive needed services (i.e., Bright Start toll-free number, care coordination

for CYSHCN and their families, translation, respite care, and parent support activities).

Population-Based Services: Allocations in this area support newborn metabolic screening, coordinated school health, injury prevention, oral health, school screenings, community immunization coalitions, immunizations, outreach and public education, risk assessment of pregnant women, child health conferences/developmental screenings, and breastfeeding activities.

Infrastructure Building Services: Allocations in this area provide funding to support program staff, benefits, travel, operating, training, supplies, materials, capital outlay, and contractual services. Activities funded include needs assessment, community coordination/collaboration, community assistance, quality assurance, policy development, program planning and evaluation, interagency collaboration, training, technical assistance to field staff and public/private partners, and data collection and analysis.

## VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

## VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

## VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

## IX. Technical Note
Please refer to Section IX of the Guidance.

## X. Appendices and State Supporting documents
### A. Needs Assessment
Please refer to Section II attachments, if provided.

### B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

### C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

### D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.